DEPARTMENT OF HEALTH AND SOCIAL SECURITY

WELSH OFFICE

Reorganisation of the National Health Service and Local Government in England and Wales

A report from the Working Party on Collaboration between the NHS and Local Government on its activities to the end of 1972

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FOREWORD

The purpose of the reorganisation of the National Health Service is to enable services to the patient to be improved. But the health services cannot be operated or developed in isolation: they depend on the humane planning and provision of a range of closely related services which are the responsibility of local government. It is therefore of great importance for the new health authorities to forge effective links and foster close understanding with their counterparts, the local authorities responsible for personal social services, education, housing and public health.

For the new local authorities, close working with the reorganised and integrated NHS will be of equal importance. They will need ready access to health skills and to draw on the support of medical, dental, nursing and other health care staff in discharging their own functions. There will also be many ways in which a sharing of goods or materials or other facilities will benefit both sets of authorities.

We have been concerned to see that arrangements are worked out which will make it possible for services of mutual concern to the NHS and to local government to be planned, developed and operated so that they meet mutual needs. This Report represents an important step towards that objective. The proposals in it have made a solid contribution to unravelling the practical problems of harmonising the development of complementary but independent services—a contribution which the Government has already recognised in the most practical way, by including some of the Working Party's principal recommendations in its NHS reorganisation Bill.

We should like to thank all the members of the Working Party and the co-opted members of its sub-committees and specialist groups who have already given so generously of their time and energies in considering these important and complex matters. And we should like to commend these first results of their work to the existing and new health and local authorities. In particular, the new authorities will have the task of making a living reality of the arrangements for joint working, of setting up the joint consultative committees and arranging the sharing of professional staff, and of developing plans for the improvement of services to their communities. There is no doubt that the Working Party on Collaboration has done a good deal to make their path smoother. Further reports on its work will follow.

KEITH JOSEPH
Secretary of State for Social Services

PETER THOMAS
Secretary of State for Wales

CHAPTER 1
BACKGROUND

1.1. The importance of co-operation between the new local authorities and the new health authorities has been a dominant theme in the Government's proposals for the reorganisation of the National Health Service which were, at the time of the report's going to press, before Parliament. Subject to Parliamentary approval of the NHS Reorganisation Bill,* the area health authority (AHA) will be the operational NHS authority, responsible to the regional health authority (RHA) for assessing needs in its area, and for planning, organising and administering area health services to meet them. But, as the White Paper on NHS Reorganisation (Cmnd 5055 Chapter VI (para 53)) pointed out, the area health authority cannot hope to do these things successfully on its own. Collaboration between the health and social services will need to be firmly established if the community is to receive comprehensive care. Co-ordination of planning and day to day work will also be important in the fields of education, housing and environmental health.

1.2. Identity of geographical areas for health and personal social services will be valuable, but close links are also needed between the health authority and the local authorities responsible for education, environmental health, housing and other services where interests overlap. These local government services will sometimes be administered by different authorities: personal social services by the non-metropolitan counties, the metropolitan districts and the London boroughs; education by these authorities except in central London where the Inner London Education Authority is responsible; environmental health and housing by the non-metropolitan districts, the metropolitan districts and the London boroughs. An additional factor in England of which account needs to be taken is that area health authorities will be working within policies determined by the regional health authority, for which there is no local authority equivalent, and that regional health authorities will be directly responsible for operating some health services, including the ambulance service in metropolitan counties and Greater London.

1.3. The consultative document "National Health Service Reorganisation" issued in May 1971 announced the intention of the Secretary of State for Social Services to set up a working party to consider arrangements necessary for close collaboration between the new local authorities and the new health authorities in services of mutual interest on the coming into effect of the reorganisation of local government and of the National Health Service in April 1974. The consultative document "NHS Reorganisation in Wales" (June 1971) indicated that the Working Party would include Welsh health and local government interests and that its conclusions should apply equally to England and Wales.

1.4. The Working Party was one of three working groups set up after the Consultative Document to study some of the basic elements in the new structure proposed in those documents. The others were: the Working Party under the Minister of State, DHSS, Lord Aberdare, which looked at arrangements for

* The Bill has now received Royal Assent. References to it, therefore, should be understood as being to the National Health Service Reorganisation Act 1973.

Greater London, and on which decisions were announced in November 1972; and the Study Group which considered the detailed management arrangements needed in the reorganised service (the report* of this Group was published in September 1972, and decisions on it were announced in February 1973).

1.5. The Working Party has the following terms of reference:

"In the context of the proposed reorganisation of local government and of the National Health Service, to consider the need and scope for collaboration and co-ordination—including any factors likely to impede or prevent them—between the local authorities and the health authorities, both from the point of view of those receiving services and the public generally and in order to ensure the most effective and efficient use of staff, buildings, and other resources; and to make recommendations to the Government on these matters."

1.6. The members of the Working Party are listed at Appendix A. Membership is broadly representative of local government, the NHS and central government, with DHSS providing the secretariat; the secretariat for the sub-committee on the school health service was provided jointly by DHSS and the Department of Education and Science.

1.7. The Working Party had its first meeting on 3 August 1971. It gave first priority to those aspects of collaboration which needed statutory backing and straight away set up sub-committees to examine certain specific fields for collaboration—the personal social services, the school health services and the environmental health services. The present report incorporates four reports from these sub-committees. A co-ordinating committee was also set up to cover points common to all sub-committees and to advise the Working Party on them. The members of these committees are also listed in Appendix A. They included several co-opted members.

1.8. The Working Party set up a further sub-committee in July 1972 to consider financial arrangements. Also during 1972 the co-ordinating committee set up four specialist groups to deal with the following specific subjects: supplies; building and engineering including maintenance of premises and grounds; management services and statistics; and ancillary services, such as catering and laundry. Early in 1973 a sub-committee was convened to consider how the various aspects of collaboration should be applied to the special circumstances in London. Reports from these groups and further conclusions of the Working Party will be published in due course. The Working Party is expected to continue to function up until the appointed day—and possibly beyond it—producing recommendations which can be issued to authorities as guidance.

1.9. The four reports reproduced in this present document were circulated for comment by interested bodies in two instalments. The first instalment, which consisted of the report on environmental health and the first report on the personal social services, was sent out in April 1972; the second instalment containing recommendations for the school health service and further proposals on the personal social services followed in August 1972.

* Management Arrangements for the Reorganised National Health Service, 1972, HMSO.

1.10. The Secretary of State for Social Services, the Secretary of State for Wales and, insofar as the education services in England are concerned, the Secretary of State for Education and Science, after considering the proposals in the light of the comments received have accepted the Working Party's recommendations. These are now accordingly embodied in the NHS Reorganisation Bill or will be the subject of guidance to be sent to the new health and local authorities.

1.11. Chapter 2 of this Report contains a summary of these two sets of proposals, and an account of the legislative provisions. Chapters 3, 4, 5 and 6 consist of the four reports which formed the basis of the proposals. The appendices and annexes to these reports are reproduced in the final appendices.

CHAPTER 2

SUMMARY OF MAIN PROPOSALS

2.1. As explained in chapter 1, the Working Party initially set up three sub-committees to consider the problems of collaboration in the fields of environmental health, personal social services and the school health services. These three sub-committees worked in parallel on the same problems, although different aspects acquired particular significance and were dealt with more or less fully according to the functions under consideration. For instance although all sub-committees considered joint consultative machinery and sharing of staff, the personal social services sub-committee paid particular attention to joint consultative committees, while the sub-committees on environmental health and the school health services concentrated more on the detailed arrangements for sharing professional staff. On several points, however, the proposals of a sub-committee are applicable only to that service. The Working Party, while broadly adopting the sub-committees' reports, rejected one or two of their conclusions. (These points of disagreement are noted at appropriate points in later chapters.)

2.2. The three sub-committees came to the same conclusions on the need for collaborative machinery between the two sets of authorities in the form of joint consultative committees and on the principles underlying the sharing of professional staff. This chapter draws together the proposals from these sub-committees and sets out the conclusions reached by the Working Party on them and on how the new health and local authorities could best collaborate.

2.3. Aspects of the collaborative machinery still being considered by the Working Party are indicated in footnotes. In addition the London sub-committee is considering how the general principles enunciated here by the Working Party can be applied to the special circumstances of local government and the National Health Service in Greater London; the conclusions will be the subject of a later report.

2.4. The proposals of the Working Party in this report have, after consultation with outside interests, been approved by the Government and are embodied in legislation or will be embodied in guidance as appropriate. The closing sections of this chapter indicate the clauses in the NHS Reorganisation Bill which are based on the Working Party proposals. Briefly however, the Bill lays down the general requirement to collaborate, the requirement to set up joint consultative committees and the statutory basis for the provision of goods and services and for the sharing of certain professional staff.

2.5. The Working Party's conclusions on the reports from the three sub-committees are arranged under the subheads below. On many points the conclusions merely endorse the proposals in summary of the sub-committees, and accordingly the subheads show references to the chapters where there are fuller discussions of the points at issue. There are references in this and subsequent chapters to documents, studies or legislative proposals which have since been superseded, changed or become law. Where appropriate, therefore, footnotes have been added to explain the latest developments.

Duty to collaborate (Chapter 4.4)

2.6. There should be a statutory obligation on the health authority and the corresponding local authority(ies) to collaborate so as to secure the health and welfare of the people of their areas. This proposal has been adopted, and is at present in Clause 10 of the Bill.

Joint consultative committees (Chapters 3.21–3.24; 4.4–4.34; 6.26–6.35)

2.7. A statutory requirement should be placed on the area health authority and the corresponding local authority(ies) to set up joint consultative committees. While flexibility to suit local circumstances would be necessary and desirable, the general pattern should be as follows:

(a) in each metropolitan district a single committee covering environmental health, personal social services, education and other functions in respect of which health and local authorities collaborate. It would represent, on the local authority side, the metropolitan district council.

(b) in each non-metropolitan county, one committee for education and personal social services representing, on the local authority side, the county council; and another, linked by common membership and collaboration between officers, for environmental health, which would include representatives of all the local authority district councils and of the county council. Other arrangements for collaboration between the area health authorities and the local authorities could be brought under whichever level of consultative committee was appropriate.

2.8. This proposal has also been adopted and Clause 10 of the Bill requires the setting up of joint consultative committees.

2.9. Arrangements for joint consultative committees in non-metropolitan counties in relation to local authority housing functions were under review early in 1973. The Working Party reached the conclusion (which is under consultation) that housing matters should generally be considered on the committee for environmental health, on which there should be representation from the county council's personal social services committee; when however housing was considered in relation to social services, it should be considered on the committee for education and personal social services, with representatives from the district councils at that meeting.

2.10. Arrangements for joint consultative committees in health districts overlapping two area health authorities are still under consideration.

2.11. The joint consultative committees should be composed of members from the two sets of authorities; but a group of senior officers from the authorities would work in parallel with and support the committees. The Working Party did not think it desirable to specify the membership of the committees but thought the working groups of officers should include chief officers.

2.12. In England the regional health authority's concern with collaborative arrangements would be reflected by its representation on the joint consultative committees at area level.

2.13. The function of these committees would be to examine jointly the needs of each area, the plans of the two sets of authorities for meeting those needs and the progress made towards meeting them; and to advise on both the planning and the operation of the services in matters of common concern. The objective would be to secure genuinely collaborative methods of working throughout the process of planning, and close and continuing co-operation between the officers of the two sides.

2.14. It would be unnecessary to provide formal machinery for resolving disputes which might arise on the joint consultative committees or between the authorities: each authority would, as now, be able to make its views known to the responsible central government department and to seek its good offices in finding a solution. The Secretaries of State for Social Services and for Wales will have powers to issue directions to the new health authorities. The Working Party, after full discussion, concluded, however, that there were strong arguments against seeking a similar specific power for Ministerial direction of local authorities in respect of collaborative arrangements in the personal social and environmental health services.

Publicity for the consultative committees

2.15. The recommendations of the joint consultative committees to their parent authorities should be made known to the public and the press in some suitable manner. The parent authorities should also report periodically to the Secretary of State on how each joint consultative committee was working.

2.16. The Working Party is considering further the arrangements for publicising the work of the committees and its conclusions will be the subject of a later report.

Collaboration at local government and health district level (Chapters 3; 4.25–4.45; 6.39–6.41)

2.17. The discussion here centred on environmental health and personal social service functions. For environmental health functions, proposals have been made for joint consultative committees and sharing staff. It was noted that administrative difficulties would be caused by the fact that health districts and local government non-metropolitan districts would not necessarily be coterminous.

2.18. On the social services side it was thought that operational boundaries of the two services should be brought into correspondence with one another to the greatest possible extent. Joint consultative committees should pay particular attention to problems of collaboration at district level to ensure that good working relationships were not impaired by organisational divergences that were bound to exist.

2.19. In planning affecting the personal social services the health authority's

district management team should communicate and consult with senior officers of the social services department in the local authority. While it would not be appropriate for such officers to act as members of the district management team, they should be drawn into consultation whenever issues of joint concern are under consideration.

2.20. Social service staff of local authority departments working at field level in the health districts should where appropriate be included in the health care planning teams which the AHA's district management teams are to set up to plan services to meet particular groups of needs, e.g. services for the elderly, children, and the mentally ill and mentally handicapped.

2.21. There would also be a need for close working between individual schools and the health staff at district level, as well as at other levels. One of the most important and continuing tasks of the joint consultative committees would be to ensure that such close working links were forged and maintained.

Co-option to local authority committees (Chapters 4.12–4.20; 6.24)

2.22. Under the proposals in the Bill each area health authority will include members appointed by the corresponding local authority, thus helping both the health authority and the local authority to understand each other's needs and policies. This would be reinforced if, in addition, other representatives of the area health authority participated in the local authority's consideration of matters of common concern. Local authorities should be strongly urged to co-opt to the committees concerned members or officers of the area health authority nominated by that authority. (Some Working Party members would have preferred to make this a statutory requirement.)

Power to provide goods and services

2.23. The health and local authorities should have full powers to provide goods and services to each other, including the services of staff and the use of premises and other facilities. The necessary provision has been included in Clauses 11 and 12 of the Bill, and the Working Party is looking in detail at the way in which such powers should be used. This will be the subject of a further report.

Sharing of professional skills

2.24. Staff with similar professional skills should be based in the same employing authority in the interests of the professions themselves and of their patients and clients. This should promote professional cohesion, facilitate career development and training, secure the most effective deployment of scarce manpower resources, and encourage collaboration through interdependence in staffing. Medical, dental and nursing staff should therefore be based in NHS employment, including those needed for local authority functions. Social work staff including those needed by the NHS should be based in local authority employment. The area health authorities should make available to local authorities the advice and support of medical, dental, nursing and other health services

staff. In particular they should be required by statute to make such staff available to enable local authorities to carry out their responsibilities in the field of personal social services, education and environmental health. Similarly the local authorities should be required by statute to make social work skills available to health authorities to enable them to carry out their health care functions. And each authority should be encouraged to look to the other for these skills. The Government has adopted these recommendations and included the necessary provision in clauses 11 and 12 of the Bill. The Working Party further recommended that the arrangements for each main service should be as follows:

(i) **Staffing in relation to environmental health** (Chapters 3.4–3.20)

2.24.1. The area health authority when invited by a local government district council to do so should arrange to second a doctor to each council as their adviser and "proper officer" on environmental health functions. Generally such a doctor would be working part-time for the district council and part-time for the area health authority. He would be appointed with the agreement of the district council who would give him a letter of appointment, as their "proper officer", under the provisions of the Local Government Bill (now Local Government Act 1972), thus making him accountable to the district council for the medical aspects of their functions. This doctor would in non-metropolitan districts usually be the appropriate health district community physician; in metropolitan districts and in some non-metropolitan districts he might well be the area medical officer or one of his staff.

(ii) **Staffing in relation to personal social services** (Chapter 5.1–5.56)

2.24.2. A statutory duty should be placed on local authorities to provide social work support for the health services and on area health authorities to provide medical and nursing support for the local authority social services. (Such duties are imposed by clause 11(3) of the Bill as regards the NHS and by clause 12(2) as regards local authorities.)

2.24.3. Local authorities should assume responsibility for social work in hospitals, but with a series of safeguards, both for the hospital service and for the hospital social workers affected. The management structure of both authorities should provide at senior level for an officer to have special responsibility for the professional support which his service is to provide for the other. Thus, in the area health authority a senior medical and a senior nursing officer should carry responsibility for ensuring the provision of, respectively, medical and nursing support to the local authority; and in the local authority a senior officer in the social services department should be responsible to the Director of Social Services for ensuring the provision of social work support for the health authority.

2.24.4. Joint consultative committees should pay particular regard to arrangements for sharing of skills; in particular, they should set up standing sub-committees to supervise arrangements for social work provision to the health services.

2.24.5. Two members of the health and social service sub-committee dissented from the conclusions on hospital social workers. Some Working Party members also thought that area health authorities should be allowed to appoint their own hospital social workers, without needing to secure the approval of the Central Department, in the same way that local authorities would be free to recruit their own medical and nursing staff. The necessity for doing so might arise where, exceptionally, an authority judged that the measure of support which it was offered was inadequate to enable it to discharge its statutory duties effectively. The Secretaries of State take the view that this is a matter for management within the NHS.

(iii) **Staffing in school health services** (Chapter 6.19–6.23)

2.24.6. There should be statutory obligations on the National Health Service: first to provide medical and dental inspection and treatment to school children, on the lines of Section 48 of the Education Act, 1944; and, second, to provide the necessary services to assist local education authorities to carry out their health related functions.

2.24.7. A senior doctor responsible for child/school health should be appointed by the area health authority in agreement with the matching local education authority, whose responsibility it would be to give advice independently to each authority. A senior dental officer and a senior nurse in the area health authority should carry similar responsibilities for dental and nursing services.

2.24.8. It would be for such senior officers to ensure that the staff working in the school environment understood their responsibility to the school and to the child. Moreover the close integration of all those working together for the furtherance of the health of children in an educational context would be a prime responsibility of the joint consultative committees.

Collaboration and voluntary bodies (Chapter 5.57–5.62)

2.25. Joint consultative committees should review arrangements with the voluntary sector in their area and develop them to ensure that:

—overlapping demands on existing organisations are co-ordinated so that the organisations are used to the best advantage of the community;

—community resources of voluntary service are mobilised by joint efforts to provide the maximum contribution to services;

—the contribution which voluntary organisations can make in joint planning of services is fully taken into account.

Child health services (Chapter 6.42–6.43)

2.26. There should be an early review of future child/school health needs. (The Government adopted the proposal and has announced the setting up of such a review.)

Ambulance services (Chapter 5.63–5.64)

2.27. Local authorities should examine the economics of different systems of transport and decide the extent to which it would be convenient to make use of the ambulance services. Local authorities and the health authorities should co-ordinate their services to ensure a comprehensive transport service and joint consultative committees should consider the development of the hospital car service to provide transport for social services as well as hospital patients.

Collection of information

2.28. The Working Party wished to draw the attention of the new local and health authorities to the importance of collecting and publishing information about comparative performance in collaborative working. It was accepted however that statistical information could not of itself give a complete picture of the extent or effectiveness of collaboration.

Statutory provisions

2.29. Clauses 10–12 of the NHS Reorganisation Bill (as introduced into the House of Commons) cover aspects of collaboration and assistance considered by the Working Party, and make the necessary statutory provision required by its recommendations. The effect of these clauses may be summarised as follows:

2.29.1. Clause 10 lays a general duty on health and local authorities to co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.

2.29.2. Clause 10 also requires the setting up of joint consultative committees between local authorities and health authorities, and gives the Secretary of State powers to make Orders relating in particular to the structure of the committees, the appointment of sub-committees, the co-option of outside members, financial arrangements and the making of reports by the parent authorities.

2.29.3. Clause 11 gives the Secretary of State power (which he can delegate to health authorities) to supply goods, materials, facilities and services to local authorities. It also lays a duty on the Secretary of State to make available NHS goods, services and facilities, and in particular the services of medical, dental and nursing staff, so far as is reasonably necessary and practicable, to enable local authorities to carry out their functions relating to social services, education and public health.

2.29.4. Clause 12 enables local authorities to supply goods, services and facilities to the NHS, and in particular lays on local authorities the duty to make available to the health authority staff employed under the Local Authority Social Services Act 1970, so far as is reasonably necessary and practicable, to enable health authorities to carry out their health functions.

CHAPTER 3

REPORT OF THE SUB-COMMITTEE ON ENVIRONMENTAL HEALTH—MARCH 1972

3.1. The Sub-Committee have identified certain specific functions which should be included with any definition of "Environmental Health" (cf Appendix B) but accepted the impracticability of attempting to list all possible functions in this area. In considering the problems of collaboration between local government and the National Health Service we have had in mind that our concern should be with the medical aspects of all the responsibilities of local government authorities. Whilst we have recognised that the major environmental health functions will be the responsibility of the new local government districts, we have not overlooked the fact that the new county councils will require medical advice in respect of certain of their functions (e.g. refuse disposal and consumer protection) which have environmental health implications. Issues concerning the medical inspection of local authority staffs as a whole will be a matter for consideration, if necessary, by the main Working Party.

The need for co-operation

3.2. There is a vital need for the closest co-operation in many fields of environmental health, since health is essentially a single problem for the community as a whole. In relation to notifiable disease for example, to overcome the effect of the split of responsibilities between district authorities and the National Health Service all branches of the National Health Service (community services, family practitioner services and hospitals) must work closely with district authorities in the prevention and control of notifiable disease. To encourage such close working, moreover, we are agreed that medical advice to the district authorities ought to come from within the National Health Service—provided that suitable arrangements could be made for this.

3.3. We recognised that the split of responsibilities might cause some difficulties for proper integration of services and therefore felt it incumbent upon us to consider whether to recommend any other statutory arrangements; we concluded that it would not be appropriate or necessary for us to do so, cf Appendix C. Some of us would however wish it to be recorded that many of the arrangements which we have recommended in this Report would not be necessary if there was not to be a split of responsibilities in some areas of environmental health between local government and the National Health Service. We all recognised however that it was our responsibility to recommend collaborative arrangements between local government and the National Health Service on the basis of their functions as set out in the Local Government Bill and the NHS Consultative Document.*

* The Bill has now become the Local Government Act 1972; and the proposals for NHS reorganisation have been embodied in the White Paper "NHS Reorganisation, England" Cmnd 5055, and "NHS Reorganisation in Wales" Cmnd 5057.

Medical advice to district authorities

3.4. Our main concern has been with the arrangements for the provision of medical advice to district councils, and we have identified five propositions against which any such arrangements should be tested.

3.4.1. The district council should be satisfied that its medical adviser was accountable to them in respect of his responsibilities for giving advice and taking executive action relevant to their own statutory functions.

3.4.2. The medical adviser should be able to function as he felt necessary within the local government context, that is to say that for action in relation to the functions of his district authority he must as appropriate be able to secure the help and assistance of the other staff of the authority.

3.4.3. The medical adviser to a district council, even though he would normally be working part-time only in this role, should be a named officer with continuing responsibilities; there should also be a named alternative officer who would act in the event of his absence.

3.4.4. On the other hand the medical adviser should be part of the health team within the area health authority (AHA) so that he would be in a position to draw fully on the wide knowledge and expertise available within the National Health Service.

3.4.5. And in order that the medical adviser should not feel himself exclusively a "local government man", but should feel part both of local government and of the National Health Service, he should have duties for both. This means that whole-time employment of medical staff by a local government district or districts should be avoided as far as possible.

3.5. We have considered whether greater flexibility and efficiency would come from a relationship by which the district council would enter into some form of general agreement with the appropriate AHA for the NHS to advise them in respect of their functions entailing medical expertise. This would not preclude—and indeed it might be an understood part of such arrangements—that the AHA would in fact identify one of their medical staff as being responsible for giving advice to a particular district council.

3.6. We have also considered whether, if such an arrangement were unacceptable, it would be possible to define the duties and powers of the medical adviser either by regulation (on the lines of sections 5 and 15 of the Public Health Officers Regulations 1959 (see Appendix D)), or in some form of detailed contract. We noted the differences between Regulations and a contract, but we recognised the common factor as being that they would both require the detailed definition of the duties and powers of the medical adviser to be in legally binding terms.

3.7. We recognised that the NHS and local government would be developing new ways of exercising their responsibilities in the future, and that the relationships between them would be developing. An imposition of unnecessary restrictions, which it might not be easy to modify thereafter, could well hamper such developments.

3.8. Considering these two alternatives we felt that the definition of duties in legally binding terms would not necessarily mean that the terms would always be interpreted inflexibly and rigidly. But we felt that there was a danger of this and that this might have a restrictive effect on the activities of the medical adviser, and thus limit the contribution which he could make to the health of the community. We were advised moreover that the introduction of statutory controls over the duties and functions of the local government medical adviser would be contrary to current thinking on the reduction in the amount of statutory control and direction of local government; indeed the powers under which the 1959 Regulations are made are due to be repealed on 1 April 1974 by the Local Government Bill.*

3.9. On the other hand we felt bound to conclude that the greater flexibility implied in the somewhat loose relationship described in paragraph 3.5 would not in fact be acceptable to many district councils, and might encourage them to appoint their own medical advisers, to the detriment of the proper exercise of the health functions both of the district council and of the National Health Service.

3.10. We have therefore sought a middle way, which, though it is not without its difficulties, should satisfy the criteria which we identified and have described in paragraph 3.4 above.

The middle way

3.11. We have assumed that there would be some reference in the NHS Reorganisation Bill to an obligation on the NHS to make available to local authorities appropriately qualified and experienced registered medical practitioners to give medical advice on the full range of local government functions. Within those responsibilities we see the area health authority arranging to "second" to the district council a doctor who would be the medical adviser to the district authority. Generally this doctor would be working part-time for the district council concerned, see paragraph 3.4 above. He would be appointed with the agreement of the district council concerned and would have a letter of appointment as medical adviser of that authority specifically under the provisions of Clause 111 of the Local Government Bill† (as a proper officer of the authority), thus making him accountable to the district council for the medical aspects of their functions. The area health authority would also, with the agreement of the district council, appoint another named medical practitioner to act in the absence of the medical adviser.

3.12. We need to define what we mean by "secondment" in this context. We envisage a situation in which the AHA would agree to transfer one of its officers to be appointed for the purposes and under the arrangements described in the previous paragraph, and to devote an agreed proportion of his time to the work of the local authority. Secondment in this sense could be for an agreed period of time or it could be indefinitely. The officer seconded would be accountable to the

* Local Government Act 1972.

† Section 112 of the Local Government Act 1972.

local government district council for the functions for which he was appointed their medical adviser, and the district council would have the right to determine what his responsibilities should be within the terms of the circulars of guidance to be issued (cf paragraph 3.14 below). The AHA would remain responsible for the long-term career of the seconded officer but would be able to look to the district council for assessments of the officer's performance of his duties for them. It would of course be open to either authority to make proposals for the officer to be transferred to other work; and neither the doctor nor the AHA would be tied to a situation which he or the AHA found unacceptable; it would be open to the officer concerned as it would be to either authority to seek that he should be transferred to other work. ("Secondment" of this kind would normally assume payment by the district council to the AHA, but financial questions are to be settled later by the main Working Party.)*

3.13. We feel that such a method of appointment would meet the desirable aim of establishing the medical adviser within the district council's team and enabling him to act effectively in that team, without breaking his link with the NHS.

3.14. We recognise that, at a time when local government responsibilities are changing and the National Health Service is being reorganised, it will be necessary for the Central Departments, after consultation with all interested parties, to issue circulars of guidance to district councils and area health authorities outlining the role and duties of the medical adviser to the district council. These circulars should cover relationships, powers and duties in regard to the functions listed in Appendix B, but might need to make it clear that the medical adviser would not be confined to specific duties and functions under the various Acts but would have the duty to give advice, unasked or on request on any matter within the responsibility of the local authority where health considerations arise. The guidance would need to be particularly detailed in relation to such functions as the control of communicable disease and food and water-borne disease, because of the particular urgency with which action needs to be taken in respect of any incidents, and the fact that the action for dealing with them would commonly involve both the district and the health authority.

3.15. We recommend action to ensure that the wide range of subjects within the field of environmental health is given appropriate emphasis in the training arrangements for those appointed as medical advisers to local government.

Status within the NHS of the seconded medical adviser

3.16. We have specifically considered whether the formal links between the district councils, non-metropolitan counties and NHS should be forged by appointing the Area Medical Officer as the "proper officer" of the district council for this purpose (on the understanding that in large measure the responsibility would be delegated to a member of the AMO's staff) or whether the medical officer at NHS district level should be appointed the "proper officer" in this respect. It has been suggested that the former (the appointment of the AMO

* The Working Party's conclusions on financial arrangements will be included in a later report.

as the proper officer) would allow the greatest co-ordination of medical effort in support of local government and might therefore be said to provide the best service. Such an arrangement would be subject to the proviso that the AMO might, by agreement with the individual district councils concerned, delegate specific duties to district community physicians. Such community physicians would be accountable to the AMO (not to the local government district council) for those duties.

3.17. We must of course recognise the force of the argument that the AMO should be appointed as the proper officer, but we have concluded that it pays too little heed to the real needs and constitutional position of the district councils. If the medical adviser to the local district council, i.e. the doctor who is giving day to day advice and support to the district council in the exercise of their functions, is to be in any way formally accountable to a senior in the AHA hierarchy this must inevitably detract from his accountability to the district council. We are advised that many local authorities would not accept such a position because they would believe that they would not be able to discharge their statutory responsibilities effectively, unless their medical adviser was directly responsible to them, was available as necessary and was able to give advice and take executive action as necessary, on the basis of his own judgment working within their local government framework, rather than at second-hand through a senior colleague.

3.18. In default of this they might make their own appointments. As this would be detrimental to the community as a whole, inasmuch as we believe that the medical adviser to the district council must be and feel himself to be a part of the AHA team, we could not recommend a solution which would encourage it. And we have therefore concluded that the pattern should be of a community physician at health service district level, appointed a "proper officer" of and thus accountable to the district council.

3.19. In making this recommendation we do not in any way under-estimate the contribution which the Area Medical Officer can make as the leader of the AHA medical team. Under our proposals he would not in fact co-ordinate local decisions or policy in respect of the district council's statutory responsibilities, but he would play a role both in making available specialist advice and expertise and creating a forum for professional discussion on medical matters. In this respect his position as a senior member of the staff of the AHA, to which the medical advisers to the district councils will also belong, would enhance his effectiveness.

3.20. We have noted that there may be some administrative difficulties created by the fact that health districts may not be coterminous with local government districts, but we do not feel that there are any matters of principle here on which general guidance is needed.

Consultative machinery

3.21. Both in order to ensure that no snags arise in the system of secondments thus described, and also to achieve co-operation generally between district councils and the NHS, there will need to be some machinery to enable the two

sides to co-operate. In the main this machinery would be at officer level, resting largely on the medical adviser/community physician who would act as a bridge between his own functions, those of the other officers of the district council, and the clinicians and specialists in the National Health Service. We have concluded however that the importance of these links was such that it would be necessary to involve the decision-taking bodies in the consultative machinery, i.e. the district councils and the area health authorities. And specifically we propose that there should be a joint consultative committee (composed of members, and supported by officers) to over-see the arrangements for co-operation on environmental health matters. We would not expect it to have frequent meetings but it should be kept in effective being and available when either side felt this to be necessary.

3.22. There will usually be more than one local government district within a non-metropolitan county which has the same geographical boundaries as an AHA, and in such circumstances it would seem preferable for there to be a single consultative committee of the area health authority and the district councils concerned, and not a separate consultative committee for the AHA and each district council separately. We have considered whether, if there was to be a joint consultative or planning committee between local government and NHS concerned with questions affecting personal social services, education and health, it would be appropriate for this joint machinery to cover environmental health matters as well. We concluded that this would not be appropriate, and that there should be a separate joint consultative committee of AHA and district councils for environmental health matters in such counties.

3.23. We believe that it is sufficiently important that there should be this consultative machinery at member level to justify requiring that it be established by statute, but that such a requirement should not lay down specific terms of reference or detailed composition—though the authorities may welcome guidance.

3.24. We do not think it appropriate to give such a committee formal statutory powers. But even if the joint committees are to be no more than consultative this should not be seen as diminishing their value or influence; their views are likely to carry great weight with their constituent authorities.

Health education

3.25. As a personal health function this is to be an AHA responsibility within the National Health Service, but it will also be within the powers of a district council in respect of health functions for which they will be responsible. We recommend that, as appropriate in discharging its powers, the district council should be guided by its medical adviser who would consult, as necessary, with the health education staff and other specialist staff of the AHA.

Port health

3.26. We recognise the complexities in the present arrangements for the administration of port health (both sea and air port). These are brought about by a number of factors including the type and legal status of the port, its size and geographical location, the extent to which the port is used for passenger traffic,

for the importation of food, and as an arrival point for immigrants. Whatever new arrangements are made for port health administration they must be flexible enough to cater for the needs of the exceptional cases such as Heathrow Airport which among other things arranges medical examinations for about 50,000 immigrants per year and the port of Manchester which extends 35 miles via the Ship Canal to the sea. For example, as now, Manchester will be within several local government districts, and will be within the area of several AHAs after NHS reorganisation.

3.27. In spite of the wide variety of ports, each with its own particular health needs, they all have and will continue to have after April 1974 a common factor. This is the need to make arrangements for medical advice and in this respect they will be in a similar position to local government district councils. In dealing with ports, medical advice is required on the following three topics:

(a) inspection of imported food;
(b) medical examination of passengers and crews for the purpose of controlling the spread of infectious disease;
(c) routine medical examination of immigrants (on behalf of the Home Office).

3.28. We recommend that for the purposes of carrying out these functions which will remain with them after reorganisation, port health authorities should receive the services of medical advisers from the appropriate AHA under the same arrangements that are recommended for the provision of medical advice to district councils. We have thus in effect concluded that there is no reason why, in this respect, there should be any difference in the relationship as between port health authorities and AHAs and between district councils and AHAs.

3.29. We would expect satisfactory arrangements to be made with no administrative difficulty, but in the few cases where problems might arise these should be resolved locally—accepting the general principle that medical advice should come from the AHA. It seems likely that in practice, the named doctor or doctors given specific responsibility for local authority district medical functions would also be given responsibility for port health functions, including the functions for which the port health authorities act as agents for central government. Any difficulties in deciding which AHA should make available a medical adviser for a particular port could perhaps be resolved in consultation with the regional health authority, and in the case of Wales, the Welsh Office.

Medical referees to crematoria

3.30. It is not for us to advise on whether district councils should be responsible for this function (with referees appointed under Home Office warrant) but, if they are, they should look to their medical advisers for advice on the administrative arrangements necessary for the provision of medical referees. The financial aspects of this are a matter for consideration by the main Working Party.

CHAPTER 4

PERSONAL SOCIAL SERVICES—MACHINERY FOR COLLABORATION—MARCH 1972

(FIRST, AND PART OF SECOND, REPORT OF THE HEALTH AND SOCIAL SERVICES SUB-COMMITTEE)

4.1. The Health and Social Services Sub-Committee has concentrated initially on whether any statutory powers are needed to promote collaboration in the field with which we are concerned. While the detailed management arrangements remain to be filled in by the Management Studies in progress for England and Wales,* it is clear from what has already been said in the Consultative Document and elsewhere that major operational and planning responsibilities in the NHS will be exercised at AHA level. The areas will correspond with the non-metropolitan counties and the metropolitan county districts proposed for local government, which will be the local authorities responsible for the personal social services. It is at this level, therefore, that the main focus for collaboration will lie, and we have considered what machinery will be required to promote that collaboration.

4.2. Our first conclusion is that the need for effective collaboration is so important that there ought to be special machinery created for the purpose, under statutory powers. There will be members of the local authority on the AHA; but for reasons discussed in paragraphs 4.12 to 4.20 below, we do not consider that this will provide a sufficient link between the local authority and the AHA to secure practical collaboration. Indeed, that is not the purpose of the arrangement.

4.3. Collaboration is needed, in the words of the Consultative Document, "for the mutually agreed planning of, and investment in, the health and related local authority services". This implies co-ordinated allocation of the resources of both authorities to provide the most effective service for the community; and it postulates a willingness by both authorities to consider the interaction of their policies. If the arrangements are to be effective, they must open the way to reallocation of the resources of both parties to conform to mutually agreed plans. We accept that collaboration cannot usefully be enforced on unwilling partners; and that unnecessary proliferation of statutory committees is to be avoided. Nevertheless, we think that the issues of policy that arise are of such importance that there should be some statutory recognition of the need for collaboration, in the form of a requirement on both sides to establish joint consultative machinery. This is too important to be left simply as a matter of good administrative practice.

4.4. We think there should be a general statutory duty on the authorities to collaborate, and we further recommend that each AHA and corresponding LA should be required to set up a joint consultative committee of members of the two authorities. We do not think it necessary for the statute to go into details

* Now published as: "Management Arrangements for the Reorganised National Health Service", HMSO 1972. "Management Arrangements for the reorganised NHS in Wales", HMSO 1972.

of the composition of such committees: this is best left to local arrangements. We should expect such a committee to be served by a committee of chief officers of both authorities, which would be able to set up specialised working groups to deal with particular problems or to undertake joint research and planning. But this, again, is a matter best left for local arrangements and should not require statutory provision. Provided the Act expresses the need for collaboration by requiring the authorities to establish consultative machinery, the detailed implementation is not a matter appropriate to statutory regulation. The collaborative machinery is most likely to operate in the proper spirit if its constitution in each area is worked out by agreement between the partners in the light of local circumstances.

4.5. We have considered whether such committees should be given teeth, and the view has been expressed in our discussions that effective collaboration will be frustrated unless the committee has financial powers—that is to say, control over the expenditure of both authorities in matters of joint concern. Some medical members have also expressed scepticism about the effectiveness of collaborative machinery unless it is given a specific and statutorily defined responsibility to prepare joint plans and, through them, to influence directly the exercise by AHAs and LAs of their respective responsibilities. They foresee a risk of creating a "talking shop" devoid of any real capacity to remedy the damage caused by fragmenting health and social care between two agencies. To overcome this they have suggested that the joint committees should be given powers to plan in their own right, to present their proposals to AHAs and LAs, and to have a direct right of approach to Ministers if either side disregarded their proposals.

4.6. But most members of the sub-committee consider that this approach disregards the constitutional realities on both sides. The AHA is to be answerable to the Secretary of State through the RHA; the LA is answerable to its electorate. Neither can put its responsibilities into commission with an intermediate body, however constituted. In particular, to invest a joint committee with powers of financial control over the activities of both the AHA and the LA would certainly be objectionable to both parties. It would interfere with the clearly defined management responsibilities of both authorities and lead to confused accountability. On the NHS side it would cut across the clear line of accountability from the AHA, through the RHA to the Central Department: on the LA side it would be inconsistent with basic principles of local government finance. An effort to vest powers of financial control in the joint committee is likely to create problems of definition and budgetary procedure which would complicate decision-making processes in both authorities and serve as an obstacle rather than an aid to progress. If the joint committee were to be given such powers, its composition would need to be laid down in a degree of detail which, as stated in paragraph 4.4 above, we think inappropriate. (There would at the least have to be an even balance of representation to prevent either side from being able to impose its views on the other and possibly some machinery for the resolution of disputes.)

4.7. We are all agreed about the need to ensure that both sides co-operate effectively, and our arguments have been concerned with means, not ends. While recognising the reservations felt by the hospital consultant members,

most of us are firmly of the view that the joint committees should be consultative. Machinery of this kind must take account of the proper management responsibilities of both authorities. If it tries to impose external control on them it will not in practice achieve the objective sought: instead of promoting collaboration it will create tensions and resentment, and the two parties on the committees will be likely to take up opposing attitudes to protect their own interests, instead of trying to draw the interests of the two sides together. A consultative role for the committees need not diminish their value or influence. We should expect the views of the committees on the proper balance of provision as between health and community resources, based on the work of officers of both AHAs and LAs working jointly, would carry great weight with both authorities. In particular, the joint committees would be able to formulate plans for co-ordinated provision of services for particular types of client in response to requests from the Secretary of State (as, for example, is being done for the mentally handicapped by RHBs and local authorities jointly at the present time in accordance with the Government's policy set out in Cmnd. 4683).

4.8. The solution which therefore commends itself to most of us is as follows:

(a) Responsibility for planning should rest with the two statutory authorities—the AHA and the LA. But it should be a statutory requirement that both should set up a committee to examine jointly the plans of the two authorities and to advise on the planning and operation of services, in areas of common concern.

(b) Through this process it will be possible for needs to be assessed and the plans of the two authorities measured up against those needs by a body representing both sides and capable of taking a broad view.

(c) The Secretary of State will be able to secure by administrative means that both sides submit their plans for discussion in the joint committee. (We understand that it is the intention that forward planning of both health and social services should be conducted through annual rolling programmes, and in calling for these programmes from AHAs and LAs the Secretary of State will be able to require evidence that they have been submitted to scrutiny in the joint committees.)

4.9. Underlying these propositions is an understanding that the real objective is not to achieve the joint consideration of plans which have been prepared separately by the two sides and brought together at a late stage to see how well they match up. It is rather, to secure genuinely collaborative methods of working throughout the process of planning, and close and continuing co-operation between the officers of the two sides. The joint committees will formally consist of representatives of management—appointed members of the AHA and elected members of the LA. They will require the support of officers from both sides, and it would accord with normal practice for officers to be in attendance at their meetings. But it will be among their most important tasks, as representing the management of the two authorities, to secure that effective arrangements are made for day to day collaboration in both planning and operational matters by officers of the AHA and the LA and to keep those arrangements under review. We should expect them to set up joint working groups of officers for these purposes: this is not a matter for statutory prescription, but could be covered by guidance from the Secretary of State.

Right of appeal

4.10. We have considered whether these consultative arrangements would command more authority if they were underpinned by some right of appeal to the Secretary of State in the event of disagreement between the two sides. While we should hope that such an appeal would rarely, if ever, be necessary (since this would amount to a breakdown of collaboration at the operational level), the existence of some procedure for reference to the Secretary of State as a last resort might underline the importance attached to the collaborative arrangements, and provide a safeguard against their disregard. It might also give considerable reassurance to both sides that they would not be putting their own interests at undue risk by entering into arrangements which entailed dependence on another authority for services or for the implementation of plans: and it might in this way, help to remove apprehensions about particular types of collaboration.

4.11. It would not accord with the intended status of the joint consultative committee that the committee itself should have a direct right of reference to the Secretary of State. Formal responsibility—both to collaborate and to implement jointly agreed plans—would rest with the two separate authorities. If either was regarded by its partner as being in default, it would be open to that partner to appeal to the Secretary of State through existing channels. If appeal arrangements were to carry any weight, it would be necessary for the Secretary of State to be able to determine any issue referred to him; and equity would require that he should be able to do this by issuing direction to either the AHA or the LA, as circumstances required. He will have the necessary authority to do this on the NHS side, where he will be in a position of direct authority in the line of management command. On the local authority side there are already available to him a variety of less direct powers (including default powers) through which he can influence the action of local authorities in the social services field, but local authority members of the sub-committee see no objection to a more specific power being vested in the Secretary of State to issue directions to local authorities in the particular circumstances of a dispute about AHA/LA collaboration, if this is necessary to give the collaborative arrangements the necessary statutory authority and to emphasise their impartiality as between the AHA and the LA.*

Cross-representation

4.12. The area health authorities are to include a number of members appointed by the corresponding local authority. (Paragraph 17(a) of the Consultative Document: "This will enable the local authority to choose members who are active in the discharge of its responsibilities for the personal social services, education and other services for which close management links between the two authorities are essential".) One question we have considered is whether there should be similar cross-representation of the AHA on the relevant local authority committees; and if so, whether there should be any statutory provision about this.

* The Working Party did not accept the recommendation of the Sub-Committee that the Secretary of State should have power to direct local authorities in respect of collaboration in the personal social services.

4.13. We have not found this a straightforward issue. Indeed, the idea of cross-representation is in a sense misleading. The Consultative Document makes it clear that the composition of health authorities is not intended to be on a representational basis. The members will be appointed for their management ability, and for possession of experience of a sort that will enable them to give guidance and direction on area objectives to their staff. Thus the members from the corresponding local authority will not be appointed to represent the interests of that local authority, but to bring relevant skill and knowledge, from their local authority experience of closely related services, to bear on the management task of the AHA. The resolution of problems of mutual concern—or of apparently conflicting interests between the AHA and the LA—is, in this light, more appropriately a task for the joint consultative machinery we have proposed above. The AHA will be a small body—a membership of 15 is envisaged—and it will confuse its role as a managing body if it is regarded as a representative body whose task is to reconcile the different interests of its members.

4.14. On this basis, it is wrong to regard the local authority members of the AHA as representatives of their local authority, or to seek reciprocal representation in both directions, with members of the AHA sitting as representatives on local authority committees. The fact that there will be some local authority members on the AHA means that the persons concerned will be in a position to speak within their own local authority with knowledge of AHA policies and objectives: to that extent cross-representation will be achieved.

4.15. On the other hand, the value of having local authority members on the AHA is that they will enable the AHA's policies to be informed with a proper understanding of local authority concerns. It seems to us that the argument is as strong for having the local authority's counsels similarly informed with an understanding of the AHA's problems and policies; and that this will often call for a degree of specialist appreciation of health issues which the local authority's own members on the AHA will not be able to give. In principle, therefore, we think it desirable that there should be some infusion of health service expertise into discussions of local authority policies, where it is relevant.

4.16. But it does not follow that this requires any new statutory provision; and we have had to recognise that there are a number of difficulties, both of principle and practice. First, local authorities are composed of elected members, and while they often exercise their power to allocate places on their Committees to non-elected members they are not in general required to do so. This lies at the root of electoral representation in local government. Second, it is a principal object of the Government's present approach towards the reorganisation of local government that local authorities should be free to a large extent to organise the management of their business and their committee structure at their own discretion, as they think best in the light of local needs. It would be inconsistent with both of these propositions to impose a special requirement on local authorities to include AHA representatives in their discussion of particular classes of business.

4.17. Such a requirement would in any case probably be pointless. It would be satisfied automatically by the mere fact that the local authority had members of the AHA in its own membership. As we have indicated the real need may be

to introduce into particular local authority discussions someone with specialist knowledge of health matters which is not possessed by the local authority members on the AHA; but no statutory provision could guarantee this. (A statutory provision which required a local authority to admit to its discussions a representative of the AHA, could hardly disqualify the local authority's own members on the AHA from acting as the AHA's representative for this purpose.)

4.18. Added to this would be practical difficulties. While social services and education committees of local authorities are preserved under Clause 100 of the Local Government Bill,* there will be no continuing requirement on local authorities after 1974 to appoint committees for other equally relevant fields of activity—housing and environmental health. So there could be no statutory committees in these fields to which AHA representation could be attached. In addition, these last two areas of local authority activity would not be conducted at county level, but at district level. AHAs will be small in size and the task for members will be complex and demanding. It would not be realistic to impose on them an added obligation to engage in a considerable range of local authority discussions at both county and district level.

4.19. Medical consultant members of the sub-committee nevertheless remained uneasy about leaving this as a matter for discretion, without any statutory obligation on local authorities to co-opt representatives of the matching AHAs on to appropriate committees. They felt little confidence in the willingness of local authorities to exercise their existing powers of co-option in a way that would ensure that health service expertise would always be available to assist local authorities in their discussions. Information about the present extent of co-option in London boroughs was not reassuring. Ideally there should be someone available to represent the NHS viewpoint whenever a local authority was discussing matters where LA and AHA interests overlapped. That person need not necessarily be a doctor—though on balance this was to be preferred. He might be an appointed member of the AHA; but in that case he should not be one of the local authority's own members appointed to the AHA, since it was mere sophistry to suggest that such a person could provide cross representation in both directions. The representative should not be selected by the local authority but appointed by the AHA. Since it appeared to be accepted as right that local government expertise should be available to the AHA by the appointment of local authority members to serve on the authority, and since it was agreed to be desirable in principle that local authority discussions should be informed by an understanding of health service issues, why could it not be made a requirement that AHA representatives be appointed to LA committees?

4.20. We have discussed this difficult issue at some length, and been unable to reach complete agreement. But it is the clear view of most of us that the arguments against statutory cross-representation are decisive. We are all agreed that it is desirable that local authorities should exercise their existing powers of co-option to the full, so as to secure that their discussions are conducted with a proper appreciation of National Health Service issues whenever these are relevant: and we recommend that this view should be commended to local authorities generally. But, while taking full account of the dissenting view set out above,

* Now Section 101 of the Local Government Act 1972.

most of us think it neither realistic nor appropriate to seek to enforce co-option. Leaving aside the objections of practice and principle, we think it highly questionable whether any advantage would be gained by imposing on a possibly unwilling (and in that case resentful) local authority the obligation to admit a lone medical voice to their counsels. The majority of the Sub-Committee are firmly of the view that the main need is to secure effective and willing collaboration, and that the proper medium for this is the proposed joint consultative committee.

Collaboration at regional level

4.21. We have considered whether our conclusions about the need for joint consultative machinery at AHA/local authority level have any relevance to the situation at regional level. While direct operational responsibilities for planning and organising health services are to be exercised at AHA level, regional health authorities in England are to have important management responsibilities in the chain of command between districts, areas and the central Department. (In Wales AHAs will be directly accountable to the Secretary of State.) The detailed management arrangements at the regional level are being considered by the Management Study. But in broad outline it is already clear that the RHA will be responsible for general planning of the NHS in each region; for allocating resources to the AHAs; and for co-ordinating their activities and monitoring their performance. They will be concerned also with services which need to be planned or organised on a wider basis than an area, and they will be building authorities for all major projects. (See the Consultative Document, paragraph 9.)

4.22. An RHA will consist of a number of AHAs, each of these corresponding with a local authority area exercising responsibility for the personal social services. It seems likely that the majority of English regions will have 5 or more AHAs, and one or two may have as many as 10 or 11. These figures illustrate that there may be a problem of co-ordinating views at regional level between the RHA on one hand and a number of local authorities on the other.

4.23. The argument has been presented to us that, in these circumstances, there might be a need for special arrangements at the regional level to enable a co-ordinated view to be formed between the RHA and the local authorities in the region on the sort of strategic issues with which the RHA will be concerned. It has been suggested that some decisions (for example, on the allocation of resources) will have to be taken at regional level on the basis of considerations that can only be weighed at that level; and that the interaction of health service and social service policies will have as much bearing on decisions at the regional level as at the area level. There is, however, no regional entity on the local government side to match the RHA; and consultation would therefore involve the RHA in dealing not with a single body able to speak for local authorities' views in the region, but with a number of separate local authorities (possibly 8 or 10). Children's Regional Planning Committees have been mentioned to us as an example of a body established to enable a group of local authorities to plan collectively in their region for certain specialised services. And we have been invited to consider whether this arrangement might be adapted to provide a regional forum for local authority interests generally in those fields where there is interaction with health service policies, and a body through which the RHA might consult local authorities on issues which affect its planning at regional level.

4.24. Our conclusion, however, is that there is no special need to create a somewhat artificial form of local authority machinery for collaboration at regional level. We recognise the need for planned interaction of health and social service policies at regional level, but think this does not imply a need for an ascending apparatus of consultative machinery at each level. Planning is not to be seen as a vertical process, with plans proceeding up from AHA to RHA level for approval in a mechanical fashion. It is rather a circular process, in which constraints imposed by central government policies, RHA policies and local authority policies will all interact on planning by the AHA. The main cross-over point in planning between health and social services will be at AHA/local authority level, and the RHA (in Wales, the Welsh Office) should become involved in the planning at that level, and be represented in joint committee discussions as necessary. In this way, rather than through separate channels of communication at regional level, the RHA should be informed of the significance of local authority policies in its region, and their implications for its own regional policies; and it should be able to ensure that its own viewpoint is taken into account by both AHAs and local authorities in the formulation of their operational plans. It will of course remain possible for these arrangements to be reinforced by informal arrangements such as periodic regional conferences of local authority, AHA and RHA members.

Collaboration at district level

4.25. While the main focus for collaboration should be at AHA/LA level much of the day-to-day working of both services will be conducted through agencies working at a lower level of responsibility than the AHA or local authority; and on the NHS side, in particular, it has become clear from the Management Studies* that substantial management responsibilities are proposed to be devolved to health districts. The district is envisaged as the basic management unit of the NHS, and its main features will be as follows:

(a) it will usually be based on the catchment area of a district general hospital, or group of hospitals, with a population in the 200,000–300,000 range (in Wales the range of population will be smaller);
(b) within the district, health services of all kinds will be integrated;
(c) there will be a district management team (DMT) composed of:
    Community physician
    One or two representatives of the medical profession
    A nursing officer
    An administrative officer responsible among other things for institutional services
    A finance officer;
(d) health services for people with similar needs will be organised by multi-disciplinary teams (health care planning teams), which will be concerned with the balance between care in the hospital and outside, between primary and secondary care, and between prevention and care.

Such teams might include social workers and other local authority staff.

* See footnote to paragraph 4.1.

4.26. Not all AHAs will be sub-divided into districts. Size is a factor here, and it is expected that about 28 out of 72 AHAs in England (outside London) will not be sub-divided, but will be "single-district" areas. But this leaves a majority of AHAs operating through two or more DMTs. In these areas the district will not be an independent level of management: it will be accountable to the AHA, and its management team (the DMT) will be composed of officers.

4.27. In these circumstances it has been necessary to consider the most appropriate arrangements for securing collaboration between local authorities and the NHS at this district level. We have also taken account of the fact that some relevant local government functions will be exercised at local authority district level within non-metropolitan counties after reorganisation in 1974. The most significant of these, so far as the personal social services are concerned, will be housing. Environmental health will be another local authority district function, and the conclusion of the Working Party is that in non-metropolitan counties there should be, in addition to the joint consultative committee covering the personal social services, a separate consultative committee covering environmental health, with membership on the local authority side representative of all local authority district councils as well as of the county council.

4.29. The Working Party envisage that, in non-metropolitan counties, the two parallel JCCs would be linked by a degree of common membership (including common membership at officer level of the supporting working groups); and that other arrangements for collaboration between the AHAs and the LAs could be brought under whichever level of consultative committee was appropriate.

4.30. Taking this last point first, we have considered whether any problem arises in non-metropolitan counties over *housing*. This has very close links with the personal social services, but the district councils responsible for it will not be represented on the JCC concerned with the personal social services. The Working Party's conclusion quoted above might lead to an assumption that in this situation it would be appropriate for housing to be dealt with in the JCC where local authority district councils are represented, along with environmental health. We do not think this is necessarily right. If formalised as the proper channel of communication in housing matters, it would create an undesirable divorce between housing and personal social services in the collaborative arrangements, with separate patterns of consultation developing for the two topics. We should prefer to assume that within local government there will be ample consultation between county and district authorities in such matters as the inter-relationship of housing and social services planning, so that the county authority will be able to ensure that housing policies are taken into account as necessary in the discussions of the JCC concerned with the personal social services. This seems to us the better and more appropriate arrangement in this case and we commend it*—while observing that it need not preclude, in appro-

* The working party did not accept this recommendation and after further discussion came to the following conclusion, on which consultations were taking place when the report went to press:
"While arrangements for joint consultative committees should be flexible, it is desirable to ensure that in the non-metropolitan counties housing matters are discussed in relation both to environmental health and social services. Accordingly it is recommended that:

priate situations, the discussion of housing matters between the AHA and the district councils direct on the JCC where those councils are represented. This must be left to good sense and the needs of the situation; and in our view it points to the need for flexibility in the arrangements.

4.31. We have not identified any other areas of overlapping county/district interest on the local authority side where similar problems might arise, and conclude that the proposition already circulated, as described in paragraph 8 above, meets all foreseeable needs so far as local authority responsibilities at district level are concerned. No further machinery for consultation is called for, but we emphasise our view that the machinery already proposed needs to be flexibly applied, and that housing in particular should not automatically be hived off into the JCC where the district councils are represented, if it needs to be discussed in the same context as the personal social services.

4.32. Apart from the question of consultative committees covering district functions, we have considered the problem of drawing the local authority social services into relationship with the NHS districts. This has proved complicated, for a number of reasons, and we have not found it possible to formulate straightforward propositions for establishing a clear and neat pattern of collaborative arrangements.

4.33. There is no parallel on the LA side to the concern at district level with planning proposals, from their first initiation, which is proposed on the NHS side. Management responsibilities on the LA side are concentrated at county/metropolitan district level—i.e. the level corresponding with the AHA. The Local Authority Social Services Act 1970 (section 4(2)) permits social services committees to establish sub-committees and delegate functions to them ("subject to any restrictions imposed by the local authority"). But this power, to establish sub-committees concerned with territorial sub-divisions of a county for social services purposes, is not, so far as we are aware, widely exercised and in any case such committees would consist of elected or appointed members and would not therefore be appropriate bodies to deal with senior NHS officers of a District Management Team.

4.34. The administrative units of the local authority social services departments, with which it might be less inappropriate for the officers of a DMT to deal, are the area teams which serve operational areas of the local authority. The Seebohm Committee* recommended that such teams should work through area offices serving populations of between 50,000 and 100,000. This pattern of organisation is being developed by the new social services departments, and its

(i) housing matters should be discussed primarily on the joint consultative committee dealing with environmental health, and the county council's social services department should be represented on that joint consultative committee;

(ii) on the county joint consultative committee dealing with social services and education, the district councils should be represented when housing matters are discussed in the context of personal social services."

* The Report of the Committee on Local Authority and Allied Personal Social Services" (Cmnd 3702) paragraph 590.

shape essentially depends on local circumstances and needs for social services. However, the area teams are only the agencies through which the LA arranges for some of its services to be delivered: the overall management and planning of services remains with the LA, and the officers of the team do not exercise management and planning responsibilities comparable with those of the DMT's officers. There is not, therefore, any real correspondence of management function and responsibility between the area organisation of the social services department and the DMT.

4.35. In addition to these divergences of organisation and function, there is a major problem about matching of boundaries. Whereas at AHA/LA level there will normally be a complete correspondence of boundaries, at any lower level there will be a complex situation:

(a) NHS district boundaries, yet to be fixed, will take account of the catchment areas of hospitals, and will normally include populations in the range 200,000–500,000.

(b) Local government district boundaries, already in process of being fixed, are designed to take account of a different range of factors, including existing local government boundaries, and will take in populations in a lower range—the guidelines given for England were 75,000 to 100,000.*

(c) Social services "areas" will be designed to meet local community needs, and will serve populations smaller still; the Seebohm guideline was 50,000 to 100,000 but experience is already suggesting that this is on the high side. The "areas" will have to take account of the arrangements for the administration of other related local authority services, but they will not necessarily follow local government district boundaries.

4.36. Thus it is possible to envisage a situation after 1974 when there will be three distinct types of territorial organisation operating within a non-metropolitan county at district level:

NHS districts, for health services;
local government districts for, e.g., housing and environmental health services;
social services "areas" for the personal social services.

4.37. It will be evident that there is no simple way of cutting through these structural complexities. But collaboration needed at district level will be of two types: collaboration in planning, and operational collaboration in day-to-day working. We have considered these separately, and concluded that different patterns of collaboration are necessary for each. In considering planning at district level we do not mean to imply that there will be any derogation of the AHA's responsibility for overall planning or that its team of chief officers at area level will not also be closely concerned. DMTs will however be involved in initiating planning proposals as well as developing and putting into effect AHA plans.

* The boundaries have now been determined in "The English Non-metropolitan Districts (Definition) Order 1972, SI 1972 No 2039".

4.38. So far as *collaboration in planning* is concerned there must be, in addition to links at area level, effective links between the DMT on one side and the Director of Social Services on the other (or his senior officers at the headquarters of the local authority social services department). There is no lower level on the local authority side with which the DMT could effectively deal in matters of planning. This means that good communications and working relationships will have to be developed between the senior officers of the local authority social services departments and all DMTs in their county or district. The suggestion was put to us that the Director of Social Services, or his representative, should be a member of the DMT, or a permanent observer at its meetings. It would hardly be appropriate, within the management structure envisaged for the NHS, for an officer of the local authority to be formally appointed to, or associated with, the team of NHS officers accountable to their AHA. However, we think it important that by less formal means it should be established as normal working practice for representatives of local authority social services departments to be drawn into consultation with the DMT when planning issues of joint concern are to be discussed. One function of the JCC at AHA/LA level should be to ensure that communications are kept open between the LA and the DMTs in this way.

4.39. We have noted with approval the proposal in the Management Study's hypothesis that the planning of health services in the NHS districts should be carried out by health care planning teams which might include local authorities' social work staff. We endorse this suggestion, which seems a promising way of securing effective collaboration in organising services at a basic level. We would hope that the teams would include staff drawn from area teams of the social services departments, so as to develop close working relationships at that level also

4.40. So far as *operational collaboration* is concerned in day-to-day working, it is evident that arrangements will have to be devised locally to establish contacts between officers of the NHS district and officers of the local authority area teams. The overlapping organisational patterns will inevitably create difficulties in establishing correspondences at the working level, and we are bound to record a fear that lack of territorial correspondence of boundaries will militate against efficient collaboration unless a determined and careful effort is made to overcome the resulting administrative obstacles. In this situation we think the JCC at AHA/LA level may have to concern itself a good deal with ironing out problems that arise on the ground.

4.41. Co-terminosity of boundaries cannot be the answer to all problems; but it can be an important factor in reducing problems of operational organisation. The fact that AHA and LA boundaries will match after 1974 is, we think, going to make a significant contribution towards effective collaboration. It follows that we would like to see as much matching of boundaries at district level as circumstances permit, so as to reduce to the minimum the dislocation and interference caused by overlapping of areas. We have to recognise that the scope for this may be limited, particularly as there is a degree of inflexibility on the local government side, where the district boundaries will be fixed by Ministerial order following elaborate statutory procedures. We hope, nevertheless, that both services will see the advantage of drawing their boundaries into correspondence with one another, wherever this is possible.

4.42. In practical terms this means that:

—NHS district boundaries within AHAs should, where practicable, correspond with local government district boundaries within counties. Given disparities of size, this would often mean that one NHS district would embrace more than one local government district;

—the boundaries of local authority social services "areas" should, where practicable, be brought into conformity with NHS district boundaries, so that a distinct group of social services "areas" would relate to each NHS district.

4.43. We urge that these objectives be adopted by the two services to the greatest extent possible, and that they be commended to JCCs as desirable guidelines for planning collaborative arrangements.

4.44. Joint consultative committees at AHA/LA level should pay particular attention to problems of collaboration at the district level, so as to ensure that good working arrangements are not impaired by the organisational divergences which are bound to exist between the two sides.

4.45. In concluding discussion of collaboration at district level, we feel it necessary to record that the situation below AHA/LA level is, quite evidently, complicated and confusing. This is inherent in the nature of the management structures on both sides. We think it will be essential for the Department to issue the clearest possible guidance to the new NHS authorities about the role of the various elements in the structure. In particular, it will be necessary to ensure that there is no confusion about the respective functions of the health care planning teams and the working groups of officers which will service the JCCs. The former, even if they include officers from local authority social services departments, are essentially agencies of the DMT, and therefore of the AHA. In other words, they are concerned primarily with the delivery of health services, and are not established for the purpose of joint collaborative planning of services between the two authorities. That major task rests clearly with the JCC at AHA/LA level, and with the working groups of officers from both sides which will service the JCC.

4.46. Our conclusions in this chapter can be summarised as follows:

4.46.1. There should be a general statutory duty on health and matching local authorities to collaborate so as to secure the health and social well-being of the people of their area (paragraph 4.4).

4.46.2. Legislation should require the establishment of a joint consultative committee by each AHA and its corresponding local authority; but should not invest this committee with specific powers or functions, and should not prescribe its membership or method of operation (paragraphs 4.4–4.11).

4.46.3. Statutory provision for cross-representation of AHAs on local authorities is not appropriate or feasible: but local authorities should be urged to exercise to the full their existing powers of co-option so as to secure an effective understanding of NHS problems when issues of joint concern are under consideration (paragraphs 4.12–4.20).

4.46.4. Collaboration between RHAs and local authorities in their regions will be most effectively secured by involving the RHA in the collaborative planning processes of the joint consultative committees at AHA/LA level. These processes may lead to other types of informal contact between RHAs and local authorities: but the main focus for formal collaboration should be clearly established at AHA/LA level, and it is not necessary to create special machinery for collaboration at regional level (paragraphs 4.21–4.24).

4.46.5. In matters of planning the DMT should communicate and consult with senior officers of the local authority social services department at county and metropolitan district level. It will not be appropriate for officers of the local authority social services department to act as members of the DMT, but they should be drawn into consultation by the DMT whenever issues of joint concern are under consideration (paragraphs 4.38–4.39).

4.46.6. Local authority social services staff should where appropriate be included in the health care planning teams which are proposed for the organisation of health services within health districts (paragraph 4.39).

4.46.7. To facilitate collaboration in day-to-day working, operational boundaries in the two services should be brought into correspondence with one another to the greatest possible extent. NHS district boundaries should follow local government district boundaries wherever possible; and local authority social services "areas" should where possible be organised so that a distinct group of area teams matches each NHS district (paragraphs 4.40–4.43).

4.46.8. Joint consultative committees at AHA/LA level should pay particular attention to problems of collaboration at the district level, so as to ensure that good working arrangements are not impaired by the organisational divergencies which are bound to exist between the two sides (paragraph 4.44).

CHAPTER 5

PERSONAL SOCIAL SERVICES—SHARING PROFESSIONAL SKILLS; THE VOLUNTARY SECTOR; AMBULANCES:

PART OF SECOND REPORT OF HEALTH AND SOCIAL SERVICES SUB-COMMITTEE—JUNE 1972

5.1. We now have to deal with an issue which lies at the heart of the problem of collaboration. Given that a boundary has to be set between the NHS and local authority services, how can resources of professional skill best be deployed so that the boundary does not stand in the way of providing the best possible service for patents and clients across the whole range of their needs?

5.2. This issue was discussed in the Green Paper "The Future Structure of the National Health Service" (HMSO 1970), and the conclusion reached by the Government at that time was stated (paragraph 31) as follows:

> "...the Government has decided that the services should be organised according to the main skills required to provide them rather than by any categorisation of primary user. Any alternative would involve the establishment of more than one local service deploying the same skill. Broadly speaking, the decision is that the health authorities will be responsible for services where the primary skill needed is that of the health professions, while the local authorities will be responsible for services where the primary skill is social care or support. The scarce skills of professional people will be used to greatest advantage if those of each profession are marshalled and husbanded by one agency in each area. Moreover it will more often be possible to provide for users the advantages of continuity of care by one professional worker of any one discipline. Classification of services by skill will also help to enhance professional standards".

5.3. While we have found, in considering the various components of this problem, much to discuss about the way in which individual services will be provided in the future, we have not found any ground for questioning the validity of the basic proposition embodied in the above passage—that health skills should be deployed from an NHS base, and social work skills from a local authority base. This seems to us to be the approach best calculated to serve the needs of patients and clients, to promote the development of professional standards, and to share effectively scarce resources of skilled professional manpower.

5.4. Our conclusions therefore derive from this approach, and we have, after much discussion, found no reason to depart from it. One argument used against it is that it creates "monopoly employers" of particular skills, and that monopolies are not advantageous to patients and clients, because they are left with no choice of agencies. But the NHS is itself a monopoly employer of a wide range of professional skills and given the circumstances in which most people turn to the health or social services for help, we find it unrealistic to suggest that they now enjoy any effective choice whether they should be helped by, for example, a hospital social worker or a local authority social worker. This depends entirely on the situation in which their need is met, not on their choice of agency. Nor can we accept that it is necessary to provide a choice of agencies to promote

(presumably through a process of competition) better standards of service. Arguments of this sort seem to us to fall short of the importance of the underlying issue. There are barriers under existing arrangements which need to be broken down, and there are shortages of trained skills which need to be husbanded to the best advantage of the community.

5.5. We have not reached our conclusions without following through the practical implications for all the professions involved, and the following paragraphs deal separately with each. We state our general approach at the outset, however, because we have found it necessary to look at all aspects of the problem, as seen from both the NHS and local authority sides, and have concluded that the logic of the situation demands a consistent approach. The health and social needs of the population interact at a multitude of points, and the services to meet them must closely inter-relate. As an example of this, we were presented during our discussion with a statement of the wide range of situations in which the nursing services in the community inter-relate with social and general practitioner services; a copy of this is at Appendix E. It would be possible to construct similar statements of inter-relationships as seen from the standpoint of the medical or social work services, and these in total would present a formidably complex picture of interlocking activities. It must be a main objective of future organisational arrangements to remove artificial barriers to these inter-relationships: and we think it can only encourage the practice of collaborative working across the boundary between the health and social services if each side learns to rely on the other for specialised professional services, rather than both trying to provide all such services for themselves (and competing for scarce manpower in the process).

5.6. The view has also been repeated in our discussions, from each professional standpoint, that it is important for the proper development of professional standards that staff in a particular discipline should form part of a single team, and that separate enclaves—for example, of nurses based in local authority rather than NHS employment—are liable to become isolated from the mainstream of developments in their profession and thereby render less satisfactory service to their clients. We regard this as an important consideration—particularly in relation to the social work profession at the present stage of its development.

5.7. Sharing of skills between the two services inevitably raises questions about financial responsibility and payment. It has been a factor in our discussions that the "receiving" authority might wish to pay for the services it gets from the "providing" authority, in order to have some sense of choice and control in the services it receives. In our discussions of social work in hospitals, for example, the idea of "seconding" a local authority social worker to work in a hospital has been taken to imply that the AHA would pay, and therefore have some say in the type of service it receives—at least in the negative sense that it will be able to decline to receive and pay for assistance it regards as unsatisfactory. The question of finance, however, lies outside our terms of reference. While therefore we touch on the question of finance in what follows, we recognise that our views will be subject to later consideration by the Working Party in a broader context, and our conclusions are in this respect tentative.*

* See Note to paragraph 3.12.

SOCIAL WORK SUPPORT FOR HOSPITALS

5.8. This topic has occupied a great deal of our attention, because it has emerged as the most controversial field with which we have been concerned. There is a sharp division of opinion within the social work profession, and many hospital social workers and medical authorities have expressed serious concern at any suggestion that social work in hospitals might cease to be provided by a separate group of social workers, with specific training in social work in a medical setting, employed directly by the NHS. Because of the controversy which has developed, we have thought it right to offer the British Association of Social Workers an opportunity to inform us of the profession's view. Representatives of a BASW working party concerned with this issue have joined us for part of our discussions, and we are grateful for their assistance. They have given us a full account of professional views, and have been very frank in expressing to us the division of opinion among members of BASW (which we understand is by no means a simple split between those members employed in hospitals and the much larger number employed outside). They have told us that the subject is one of continuing debate within the Association.

5.9. We for our part have explained, in these discussions with representatives of BASW, that we have necessarily set its consideration of this topic in the wider context of sharing of skills between the services, in both directions. We have expressed our view that the issue is one which cannot be settled solely by reference to the wishes of the staff concerned, important though these are, since wider issues of public policy and professional concern arise. We understand that the issue will remain open until there has been opportunity for comment on the Working Party's conclusions. In reaching our own firm conclusions, we have taken full account of the many representations which have been made, either in writing to us, or to the Department of Health and Social Security, by those arguing against any transfer of responsibility to local authorities.

Arguments against transfer to local government

5.10. The arguments presented against a transfer to the local authorities may be summarised as follows:

5.10.1. It is not possible to reconcile the "generic" family-based approach to social work advocated by the Seebohm Committee and now adopted by local authority social services departments, with the specialised role of the hospital social worker as a member of an integrated clinical team.

5.10.2. Area health authorities should, as a matter of principle, be responsible for the social care of their patients and families as an integral part of a comprehensive health service. AHAs should therefore employ their own social work staff in all the services administered by them, including general practice and health clinics.

5.10.3. The monopolistic control of all social work by the local authorities would deprive the client of any choice. If the local authority cannot offer help or offers inappropriate help, the hospital social worker should be able to bring pressure on the local authority or to offer alternative assistance.

5.10.4. Local authority social workers employed in hospitals would be accountable to two authorities with different priorities.

5.10.5. Hospital social workers are part of multi-disciplinary teams which undertake the diagnosis, treatment and rehabilitation of patients. As an integral part of that team the social worker should have the same employer as the other members.

5.10.6. Hospital social work requires a special aptitude and training and standards can only be improved if the social worker is committed to hospital work. A transfer to the local authority would lead to the end of medical social work as a specialisation.

5.10.7. Effective social work in hospitals depends upon the mutual confidence of medical, nursing and social work staff which takes years to build up. Directors of Social Services must be free to deploy their own staff as they think best. If hospital social workers were members of that staff they would be liable to be moved to other work, depending upon the needs of the local authority as a whole and continuity within the hospital teams would be endangered.

5.10.8. The concept of general purpose social work, accepted by local authorities, might if applied to hospitals, result in the appointment of staff without appropriate training or experience, with a consequent lowering of the standards of care.

5.10.9. Many social workers are prepared, and are suited, to work only in hospitals. If they were posted to other work they would either leave the service or contribute to a lowering of local authority standards.

5.10.10. The area system of social work in local authorities would present hospitals with a large number of channels of communication which doctors and ward sisters would not have the time to use. An efficient hospital service requires that the doctor or nurse should be able to turn to a small and constant team of hospital based social workers to provide support for their patients.

5.10.11. In addition to the care of patients, hospital social workers are required to assist in the training of medical and nursing staff. This can be done only by specialist medical social workers.

5.11. Underlying these arguments there are, we think, four main strands of concern:

—transfer to local authority employment would lead to the withdrawal of social workers or break up the cohesion of the health care team in the hospital, and undermine the specialised contribution that social work makes in the hospital setting;

—the specialised skills of trained medical and psychiatric social workers will be watered-down and undervalued in a local authority setting, and hospital-based staff exposed to transfer to areas of work for which they are unfitted by training and inclination;

—local authorities will not be responsive to health service needs and standards of social work care in hospitals will decline; and
—reliance on a local authority based service will be less convenient for hospitals.

Advantages of transfer to local government

5.12. While understanding the reasons why this concern should be expressed we think that there are other considerations which are of greater weight, taking a broad view of the community and professional needs. We touched on some of these in paragraphs 5.1–5.7 and accepted the proposition that health skills should be deployed from an NHS base and social work skills from a local authority base. Applying this proposition to social work support for hospitals we believe that a transfer to local authority responsibility would:

—remove the barriers standing in the way to providing the best possible service for patients and clients over the whole range of their needs;
—benefit both the health and local authority services by providing for the best use of scarce resources of skilled professional manpower;
—enable hospital social work to remain in the mainstream of professional developments and
—assist the development of interrelationships between the authorities.

5.13. However we recognise that the very real concerns that have been expressed can be allayed only through the introduction of positive safeguards for health care teams in hospitals and the establishment of effective machinery for collaboration between the authorities. We discuss this in detail in the following paragraphs and believe that if our recommendations are accepted they would assure the continuity of the existing health care teams in hospitals and would also:

—encourage the development of social work in those areas of the hospital service where it is now lacking;
—provide for a more effective continuity of care of the client while in hospital and of the patients returning to the community;
—assist the development of social work training to meet the changing demands on social workers;
—offer hospital based social workers a wider and more immediate range of specialised support; and
—lead to a better career structure for social workers generally.

Distribution of hospital social workers

5.14. Social work support is at present very unevenly spread in the hospital service and it is understandable that those hospitals with well-staffed departments and satisfactory arrangements at present should be nervous that change may be for the worse, not the better. But for many hospitals the need is not to safeguard existing standards, but to fill gaps. While some hospitals have teams of 10 or more social workers, the majority have 2 or 3 only, and a great many have virtually no social work support. Figures relating to the situation at 30 September 1971 show that out of 300 HMCs, 93 had no full time medical social workers or psychiatric social workers and 74 (or 27%) had no qualified social workers at all. There were substantial regional variations. Taking as a measure the ratio of

hospital beds to social workers, the variation was from 219 in one London region to 798 in a provincial region—the average being 484. The figures for PSWs in proportion to beds for psychiatric patients varied to greater extremes, from 175 in one London region to 3,029 in a provincial region—the average being 1,030. Within those figures, teaching hospitals enjoy markedly better staffing ratios—one social worker for 69 beds on average. They employ a large percentage of the qualified staff in the hospital service—over 32% of MSWs and 30% of PSWs.

5.15. Other figures relevant to a consideration of this problem concern the present distribution of social workers as between hospital and local authority employment. In whole time equivalents, the figures available to us suggested that, of all social workers employed in the two services, 85% are in local authority services. Taking MSWs on their own, nearly 90% are employed in the hospital service.

5.16. It would be wrong to place too much weight on these figures. The concentration of MSWs in the hospital service is to be expected, as is the concentration of skills in teaching hospitals. Nevertheless, we think it open to considerable question whether the distribution of skills suggested by the figures represents a rational deployment of resources, or the most advantageous one for the community. There seems little argument that the complete absence of social work support in many hospitals is a serious gap in present arrangements.

Demarcations in social work

5.17. We think the separation of a comparatively small (if specialised) sector of social workers in hospital social work is unlikely to match the way in which the social work profession itself is developing. Divisions between various groups of social workers are breaking down, not merely as a result of the family-orientated service which local authorities are in various ways seeking to promote following the Seebohm reforms, but as a result of developments in training over the past decade. Social work teaching is increasingly moving towards a more broadly based approach fitting students to work in any social work setting: and under the new Central Council for Education and Training in Social Work this trend will develop further so that the terms "medical social worker," and "psychiatric social worker" will cease to be descriptive of social workers with a form of training based on the special medical needs of clients. This will not reduce the scope for later training in the special features of social work carried out in a hospital setting and will not reduce the inclination of some social workers to that type of work. But it will develop within the profession a greater capacity to move between various types of social work, and this is likely to reinforce the trend towards less rigid demarcation of groups within the profession, so that the preservation of hospital social work as a separate basic specialisation will become increasingly unrealistic. We think this has material implications for the future organisation of the services and that isolation of a group in separate hospital employment, on the basis of a separate professional expertise, will be disadvantageous to the social workers concerned and out of step with the way in which the profession as a whole is developing.

5.18. To resist this trend will in the long run, we think, put hospital social work at a disadvantage. It is already claimed that developments in local authority social work services are drawing staff away from hospital employment. We do not find this a material factor at present: there is evidence that hospitals are still succeeding in attracting new social work staff at as great a rate as they did before the present developments in local authority services took place in 1970—though this is at less than half the rate of the growth of local authority social services departments. Present disparities in pay between the two sectors do not appear to be preventing the hospitals from maintaining and expanding their social work service at present. But in the longer run disparity in career prospects, with the much greater opportunity offered by the larger local authority social services departments, is likely to work significantly to the disadvantage of hospital social work, if it continues separately from (and in competition with) local authority social work. A separate compartment of social work, outside the mainstream of community social work departments, will appear increasingly unattractive as a long-term career prospect to future generations of social workers trained to work in a broader context. The less favoured areas of the health service which are already unable to attract social workers into hospital employment will stand increasingly less chance of doing so, if the present organisational pattern of two separate services is maintained.

Continuity of client and patient care

5.19. This last point leads to the over-riding consideration: what pattern of employment will provide the best service for patients and clients? The need is to provide services which span the full range of personal needs. Some patients in hospital have no need of social work support except in relation to their experience in hospital: for them hospital-based social workers with special skills in the hospital and clinical situation are needed. Others enter hospital from a background where they have had, or needed, social work support in the community previously; for them some understanding of their background of social needs is required by the hospital team, and a link between the social work given previously outside the hospital and now within the hospital is needed. Others, previously unknown to the local authority social services, will have a need for social work support in the community following their stay in hospital; the hospital team needs to be able to introduce them to the appropriate local authority services on discharge, and to make arrangements for their transition from hospital care back to the community. Finally, hospitals receive some patients who are moving from social care in the community into hospital for treatment, and will return to social care afterwards; for them an uninterrupted understanding of the attention to their social needs through the whole process is desirable.

5.20. We find that this points decisively towards continuity of patient care between the hospital and the community setting—and towards an integrated organisation of the social work support which the patient needs. The particular contribution to patient care which can be made by a social worker based in a hospital setting, experienced in hospital skills, and accepted as a member of a clinical team, is an indispensable part of the total range of care. In many cases it can provide all the social work support the patient needs. But where a patient needs social work support before or after his hospital experience, the hospital

social worker's task must link up with the community based services, and she needs unimpeded access to them. The patient's needs are likely to be preponderantly outside the hospital, with the hospital experience forming an interlude only: the organisational structure best adapted to this situation is, we are clear, one in which the hospital social worker is a member of the same team as the social workers employed in the community services, with access to those services as a partner in the team. In some fields of health care, particularly in mental health, there is in any case a trend towards movement from hospital based to community based team work—a concept which implies continuity of medical as well as social care in integrated area services.

Transfer to local authority responsibility

5.21. Thus our central conclusion on this topic is that social work support for hospitals should be provided by local authority social services departments, as one element in their total pattern of provision for the community; and that social workers in hospitals should be transferred to local authority employment on the date of NHS reorganisation. It has been suggested to us that this process of once-for-all transfer on an appointed day is not necessary; and that flexibility should be allowed, so that hospital social workers can remain in either NHS or local authority employment after the appointed day according to local arrangement. The basis for this suggestion is that a process has already begun to develop, in different areas, of bringing hospital social work under the aegis of the local authority social services department; that various approaches are being tried through the differing local arrangements; and that it would offer scope for experiment, in an uncertain situation, if this process could be allowed to develop organically so that the problem might sort itself out over a period by local consent. The difficulty about this is that if, as we would expect, the present trend towards local authority based employment continued (and possibly accelerated), the declining sector of social workers in separate NHS employment would be left in a progressively more isolated position. We have been told, moreover, that this course of local option would create considerable problems of providing an adequate separate pay and career structure for the potentially diminishing number of social workers left in NHS employment. We think it better that a firm decision, one way or the other, should be taken at the time of NHS reorganisation. This will offer opportunity (which will otherwise be missed) to include in the legislation any provisions needed to safeguard the interests of staff transferred, which may be a matter of some importance.

Safeguards for the hospitals

5.22. Transfer of responsibility need not, and should not, result in some of the situations listed in paragraph 5.10. In particular, there should continue to be hospital-based social workers with particular skill and experience of work in the clinical situation. Many of these should serve for extended periods in hospitals, both to acquire and preserve the necessary skills of hospital social work and to maintain continuity of experience with the clinical team in the hospital and retain the confidence of other members of that team. In their professional work within the hospital team the social workers must clearly be accountable to the team—

and we do not think that apprehensions about divided loyalties are well-founded, since the local authority's management responsibilities for the social workers will not in practice intrude upon the professional relationships between the social workers and the other members of the hospital team in the handling of cases. Finally, the training role of hospital social workers will have to be maintained, in the long-term interests of social work and health service training, and concentration of staff in teaching hospitals will continue to be indispensable, both to provide this training and because teaching hospitals draw their patients from a wide area. (On this last point, we are assured that local authorities are well accustomed in other contexts to having to shoulder particular local responsibilities for specialised types of establishment, and will see nothing unusual in having to provide a particularly high level of social work support for hospitals which require this because of their teaching role or the specialised facilities they offer, and which draw their patients from a wide area.)

5.24. Given the evident apprehensions on these points expressed in many of the representations we have received, we have given considerable thought to the arrangements which might be made to ensure that the needs of the hospitals are met, and to reassure the staff concerned that their interests will not be overlooked or their skills devalued. We have reached agreement on a number of points.

(1) A statutory duty

5.25. First, we think that a statutory duty should be imposed on local authorities to provide social work support for hospitals and, more widely, for the health services generally. This may not be strictly necessary, as it is already within the powers of local authority social service departments to provide this support. Nor can it impose on local authorities an obligation to meet all demands of AHAs without regard to existing staffing levels and the availability of staff. We have already recommended—and the main Working Party has agreed—that both health and local authorities should be under a statutory duty to collaborate; we think that, at the time of a transfer of responsibility from the NHS to local authorities, there would be advantage in adding to this a statutory obligation on local authorities to provide the social work service which the AHAs will rely on them to provide in the future. This will have some presentational advantage, in stating clearly where the responsibility will lie.

(2) JCCs—Standing sub-committees

5.26. Second, we assume that this will be an area of collaboration likely to engage the attention of the joint consultative committees sufficiently to justify the establishment of a standing sub-committee of the JCC to keep it under particularly close review. We recommend that JCCs be urged to establish such committees initially. (Later experience may well, as we would hope, show that there are not such problems in this area of collaboration to warrant retaining a special sub-committee: but it would be desirable none the less to provide machinery for paying special attention to this in the initial stages.) The fixing of complements of social workers for full-time or part-time work in hospitals will be one important matter for discussion.

(3) **Management responsibility with the LA**

5.26. Third, we think that in each local authority social services department there should be a senior officer with a special responsibility to the Director for arranging the social work support for the AHA, and to be a point of contact for the AHA management in these matters.

(4) **A working party to review arrangements**

5.27. Fourth, we think there is a need for a comprehensive review of working arrangements in this area, to consider, in greater detail than we have been able to attempt, the practical problems that will need to be resolved if social work support for the hospitals is to be provided by local authority social services departments. There are a range of issues on which guidance would be valuable—

5.27.1. appropriate levels of staffing;

5.27.2. the best use of specialised medical and psychiatric social work skills in a more broadly-based local authority service;

5.27.3. organisational arrangements for maintaining continuity of case working between the hospital and the community—i.e. how best to permit community based social workers to contribute to the care of their clients when they enter hospital, and hospital based social workers to contribute to the care of patients when they leave hospital;

5.27.4. arrangements for securing the necessary degree of continuity of service of social workers in hospitals;

5.27.5. appropriate patterns of deployment for social workers based full-time and part-time in hospital respectively;

5.27.6. the sharing of confidential records between medical and social work staff, as partners in the caring and healing team;

5.27.7. the provision of supporting clerical and other staff for local authority social workers in hospital.

5.28. We think it would be helpful if these matters could be discussed further in the period before reorganisation, so that general guidance can be made available to the new authorities who will be responsible for operating the new arrangements from 1974 onwards. We do not feel we are a properly constituted body to tackle these matters, and would see advantage in their being studied by a specially constituted group with full representation of all the interests directly concerned including hospital social workers. In particular, we should hope that some of the concern felt in certain professional circles could be eased if their representatives were able to participate in a constructive and forward-looking study of future working arrangements. We recommend, therefore, that the Secretary of State should appoint a suitable group or working party to tackle this at an early date.

(5) LA undertaking not to reduce existing levels of service

5.29. Fifth, we think it very desirable that there should be a clear understanding that the transfer of responsibilities to the new local authorities in 1974 should not lead to the unilateral withdrawal of social workers in hospitals or to intervention by local authorities to reduce existing levels of social work provision in hospitals. We have no reason to suppose that this would happen; and local authority representatives on the sub-committee have suggested that the new local authorities, through their associations, would be very willing to urge the new authorities to give an undertaking that they will not reduce or alter existing levels of staffing following the transfer except in consultation with AHAs. Such an undertaking would cover any question of moving staff in post on the appointed day, or appointing new staff after that date; and through the JCC ample means of consultation would exist from the outset. We think it would be helpful if such an undertaking could be given, and recommend accordingly.

Other safeguards: finance and default powers

5.30. The five proposals so far outlined would be aimed at ensuring effective and acceptable arrangements for the organisation of social work support in hospitals in the future, with reasonable safeguards that they will be operated sensibly. We have also discussed the situation that might arise if an AHA was not satisfied by the results of these arrangements. Two further safeguards have been suggested, but we are less clear on the need for these.

5.31. The first concerns the basis of the hospital social workers' employment, including payment. We have made it clear that we think that under the new arrangements social workers should continue to be assigned to full-time work in hospitals and employed as members of the clinical team in hospital. This, however, gives rise to questions about financial responsibility. Some members of the sub-committee, on the National Health Service side, feel that the only effective way in which the AHA can exercise any control over the services provided by the local authority is for the AHA to pay for those services and for the staff concerned to be seconded to NHS employment. They suggest that this would also safeguard the local authority against unrestrained demands from the AHA for social work support. On the other hand, the imposition of a duty on the local authorities to provide the service (as we have recommended) would seem to carry some implication that they should be responsible for the cost (in which case the added financial burden would, we assume, be taken into account in Rate Support Grant negotiations). Introduction of the principle of payment might have unwelcome consequences in distorting priorities, given an overall shortage of trained social workers, in that social workers might be assigned as between hospital and community service according to financial considerations rather than an assessment of need. Further, a situation in which the hospitals would, so to speak, buy staff from the local authority and then use them entirely at their own discretion, could well introduce a new element of divisiveness at a time when social work should, we think, be developing as an undivided service spanning any local authority/NHS boundaries.

5.32. We recognise that financial matters will be discussed in a broader context than the provision of this particular form of support to hospitals. At this stage, however, we can only set out the different views expressed in our discussions, and draw them to that sub-committee's attention. Some of our medical members attach the greatest importance to the principle of payment by the NHS as a necessary safeguard in this particular case, and regard it as justifying a special exception, if the general pattern of financial arrangements were to be based on the principle of each service providing support for the other without receiving payment. Local authority members on the other hand would prefer that responsibility for payment went with responsibility for providing the service; but if the question of payment is a critical matter of an essential reassurance, if our main proposals were to be accepted, they would not oppose this.

5.33. The second safeguard lies in the possibility that the AHA might, in default of what it considers to be adequate support from the LA, continue to employ social workers of its own even after the responsibility has been formally assigned to the LA. The idea of a default power is not relevant here, since it will clearly continue to be within the power of the NHS, as we understand it, to provide whatever services are needed for the care of patients, and this will continue to extend to social work. In other words, though the LA will be given a duty to provide social work support in hospitals, there will be nothing in law to prevent the AHAs from providing it as well. It is inherent in the whole basis of our consideration of this subject that we do not think it appropriate or sensible that both authorities should attempt to provide the same service, and compete for scarce staff to do so. Where the inadequate service, as seen by the AHA, results from a failure by the LA to recognise or agree the extent of the AHA's needs, the JCC will provide a forum for thrashing this out, and any unresolved disagreement can be referred to the Secretary of State through processes discussed in our previous report. Where it results from an inability to recruit sufficient staff to meet the AHA's need, we think it unlikely that the AHA will be better able to recruit directly for itself, where the LA has failed. So we should not regard this as a very promising solution to any future difficulties. Nor, since it presupposes a situation in which collaboration will have broken down, do we find it a very attractive basis for planning. Nevertheless, medical members argue that while the local authority should normally provide social work support, if they failed or were unable to provide an adequate service, the health service should be free to exercise their power to employ such staff as it considers necessary, on the basis of clinical judgement, in the interest of the patients. They feel that an AHA should, in such circumstances, be able to employ their own social workers as a matter of course. However, if our recommendations of the transfer to local authority employment is accepted, the staffing structure of the NHS will not, in future, provide for social work grades and it would rest with the Secretary of State to authorise the employment of social workers by an AHA in particular circumstances. While we hope that action by the joint consultative committee would avoid a situation arising in which an AHA felt the need to employ its own social workers, it would remain open to the health service to apply to the Secretary of State in exceptional circumstances.

Safeguards for staff

5.34. We have finally considered the position of the existing staff affected by the proposed change, many of whom, to judge from the representations we have received, are very uneasy about it. Our local authority representatives have been understanding of their apprehensions, and have informed us that their associations would be prepared to advise all local authorities that any personnel who are employed in social work in hospitals on the appointed day and wish to remain working in hospitals should be allowed to do so. We should welcome such a step, which would offer reassurance to many social workers engaged in hospital employment at present, and we would recommend that the associations be asked to advise their members accordingly. There will, we understand, be provisions in any legislation transferring staff to local authority employment designed to safeguard their interests against disadvantage from the transfer. If it is feasible to include in those safeguards a provision ruling out transfer from hospital-based employment without consent, we recommend that this be done also.

5.35. The anxieties expressed to us are not wholly, or even mainly, based on a reluctance on the part of existing hospital social workers to change their employment, but on a conviction that hospital social work is a field to which many social workers feel a particular commitment, and that it will be harmful to the interests of the work in future if there were no longer opportunities for social workers to apply for, or remain in, this type of work. This is, we think, an understandable and legitimate ground for concern. We think it desirable that it should continue to be possible in the future for social workers to apply for posts in a hospital setting with some assurance that they will not be liable to arbitrary transfer into other fields of local authority social work. We have considered the possibility of special contracts of employment for such posts, with a built-in guarantee against transfer. These, we have concluded, would not be a desirable development. They would perpetuate inflexibility in the deployment of staff, and would be unwelcome within the profession as conferring preferential rights on a group of staff who are intended to form part of a broader-based team. But we understand that the local authority associations would be prepared to advise their members to follow the practice of making it clear in advertisements when they are recruiting staff to work exclusively in the hospital field, and to guarantee that the nature of work of any person so appointed would not be changed except by consent. This seems to us a helpful suggestion, and we recommend that it be adopted. It is the type of matter which might be further studied by the working party whose appointment we have recommended in paragraph 5.28 above.

Summary of conclusions on hospital social work

5.36. We have dealt with this topic at length because of the degree of concern and controversy that has surrounded it. But we are not in doubt about our main recommendations, which may be summarised as follows:

5.36.1. The responsibility for providing social work support in hospitals should be formally transferred to local authority social services departments at the time of NHS reorganisation.

5.36.2. Local authorities should be placed under a statutory duty to provide social work support for AHAs, as part of their social services functions.

5.36.3. JCCs of AHAs and LAs should set up standing sub-committees to supervise this area of collaboration.

5.36.4. In each social services department there should be a senior officer with a specific responsibility to the Director for arranging social work support for the AHA.

5.36.5. The Secretary of State should arrange for a working party to prepare guidance, in the period before reorganisation, on all aspects of the working of the new arrangements.*

5.36.6. The new local authorities should be asked to give an undertaking, through their associations, that existing levels of staffing will not be altered at or after the appointed date without consultation.

5.36.7. Local authorities should be advised, through their associations, that staff in hospital employment at the appointed day should not be moved out of hospital employment without their consent.

5.36.8. If additionally a statutory safeguard against removal from hospital-based employment can be included in the provisions transferring existing hospital social workers to local authority employment, this should be done.

5.36.9. Local authorities should be advised to indicate in future when they are recruiting staff specifically for work in hospitals, and should not move staff so recruited to other social work employment without consultation.

5.37. Before leaving this topic, we should refer to the question of pay. It is asserted that hospital social work has been at a disadvantage in the past because local authority social work employment has been better paid. Whatever the strict relativity between the relevant NHS and LA salary scales, local authorities have in fact had greater flexibility and been able to offer higher starting salaries. We have not found this a critical factor at the present time. But in any case the whole question of social workers' pay, and of the relativity between probation officers, local authority social workers and NHS social workers, is under review at the present time. If our recommendation that hospital social workers pass into local authority employment is accepted, disparities should not exist, and we think it right to record this view.

5.38. We have dealt at some length with the problem of social work support for hospitals which was the most controversial of the subjects we considered. The comparative brevity of the following sections does not imply that we considered these matters of any lesser importance but rather reflects the large measure of agreement on how they should be arranged.

* This working party was being set up at the time of going to press of this report.

Note of dissent by Dr T H D Arie and Dr J Wedgwood

5.39. Two of our members, however, Dr Arie and Dr Wedgwood, dissent from the recommendations as they affect hospital social work. While Dr Arie believes that a unified social work service based on a strong local authority department is probably the most desirable pattern to aim at, he feels that the safeguards proposed would not be adequate to secure the indispensable continuity of hospital teams. Many of the problems would have been overcome if real powers, and clearer accountability, had been proposed for the JCCs. Dr Wedgwood does not consider it has yet been established that hospital social work should be based on local authority departments.

5.40. Both Dr Arie and Dr Wedgwood feel that it is essential that hospitals should, as a matter of course, be able to recruit their own social workers (with parity of salaries etc.) if the local authority is unable or unwilling to maintain effective hospital teams. Dr Arie and Dr Wedgwood also regard it as important that hospitals should pay for the social work received from local authorities, as a means of helping to underpin the right of hospitals to participate in the process of appointment and deployment of hospital social workers.

Social work support for general practice

5.41. Arrangements for collaboration between social workers and general practitioners have existed for 20 years. In some cases individual social workers have been attached full-time as an experimental project, in others a scheme for provision of some social support has been arranged by the practice doctor and the local authority health departments, or since 1970, social services departments. The development of health centres has increased the interest of doctors and social workers in team work in the practice setting, and a number include facilities for local authority based social workers to visit and interview patients referred by the doctors. The recently published report, "The Organisation of Group Practice", by a sub-committee of the Standing Medical Advisory Committee recommends the attachment of social workers for case-work and assessment of psychosocial problems. The report stresses the opportunities for preventive work.

5.42. General practice is a good pick-up point for social problems. Many people will turn to a doctor in the first place when their real need is for social work support; and often other agencies will refer such a person to his doctor in the first place, because the general practitioner is widely identified in the public mind as a person with a responsibility for each patient on his list. We think it most desirable that, as resources permit, LAs should concentrate on building closer working and team-work relationships with general practitioners. In the present state of development there may still be reluctance to be overcome among some doctors to recognise the value of close links with the social services. But doctors should find it increasingly easy to establish good communication with the new area organisation of local authority social services departments that is developing, and may find these contacts helpful in gaining access to a wider range of local authority services.

5.43. At present many doctors have to rely on telephone communication with the local authority department to refer a case to a social worker. But the attachment of local authority based social workers to group practices and health centres seems likely to offer a better basis for team working by doctors and social workers, and a better opportunity of identifying social work needs. In our view this is the pattern of service to be encouraged, and we think it should be an objective of the LA and AHA jointly to develop this method of working, as local circumstances permit.

5.44. This will be a fruitful area for attention by JCCs: and it should be a responsibility of the senior officer of the local authority social services department charged with oversight of the arrangements for social work in hospitals (see paragraph 5.25) to promote development of communications and team-working between social workers and general practitioners as well. We have already suggested that a statutory duty be imposed on LAs to provide social work support for the NHS (paragraph 5.26); in doing so we have had it in mind that this would cover the field of general practice, as well as social work in hospitals.

Medical and dental support for local authority social services

5.45. We do not discuss the dental services separately in this section of our report: but it can be assumed that our references to medical services are intended to embrace dental services.

5.46. The Medical Officer of Health is, at present, the medical adviser to his authority. On his transfer to NHS employment the social services department will continue to require a source of medical advice and support. Individual clients of the social services department, whether in their own homes or in residential accommodation, will have normal access to their own general practitioners; but the Director of Social Services and his officers will need medical advice in connection with the general development of social services.

5.47 In considering this topic we were greatly assisted by information which was provided for us by senior officers of Devon County Council about working arrangements in that county; and at one of our meetings we had a helpful discussion with the Director of Social Services and the Deputy County Medical Officer. They explained that the county's social services department had from the outset been developed on lines aimed at establishing full co-operation between medicine and social work. The health department's administrative boundaries had been brought into conformity with social services' area boundaries, and the Deputy County Medical Officer had been seconded to work half time in the social services department (and in practice spent considerably more than that proportion of time on the department's work). In this capacity she was able to act as a member of the department's senior management team; and she found scope for a wide range of activities in support of the department's work, ranging from staff training to the medical aspects of work on adoption, battered babies, care of the handicapped and elderly, and drug addiction. She was able to facilitate communications between the department, hospitals and general practitioners.

5.48. We found this evidence valuable as demonstrating the wide range of situations in which medical advice can be invaluable to social services departments; and it confirms our view that there will be a need for special arrangements to be made after reorganisation to ensure that these departments continue to have access to medical advice.

5.49. We were not, however, persuaded that the particular solution adopted in Devonshire, which centred on the secondment of a medical adviser to work within the social services department, would be an appropriate pattern for the future. It was obviously working excellently in Devonshire, as a result of the personal commitment of the officers concerned. But we fear that an arrangement of this kind could, in less favourable circumstances, lead to the seconded medical adviser becoming the sole channel of medical advice, and becoming divorced from the AHA. We prefer to rely on collaboration through a variety of channels at all levels of working between doctors based in the AHA and social workers based in the LA, and think this more likely to break down barriers between the two services than the cross-posting of medical staff into social services departments.

5.50. We conclude therefore that the best means of achieving the necessary degree of access by the local authority to the wide range of medical support needed would be through the appointment within the AHA at area level of a specialist in community medicine specifically charged with liaising with, and assisting, the local authority in his area. This is in accordance with the view of the Working Party on Medical Administrators. It would not be the function of this specialist to act as the sole point of contact for the local authority social services department. There will have to be a wide range of contacts at all levels, and the Working Party on Medical Administrators has additionally recommended the appointment of specialists in community medicine at health service district level, part of whose duties would be to promote the development at that level of effective working relationships between the health and local authority social services. The responsibility of the specialist at area level will be to ensure that effective communications and working relationships are established at all necessary levels, and that the medical support required by the local authority is available; he should be the point of contact and reference for the local authority in matters that concern the planning of such support.

5.51. We also conclude that it would be desirable to place on the AHA a statutory duty to provide medical support for local authority services. This would be the counterpart of the duty we have suggested (in paragraphs 5.25 and 5.44) for local authority services to provide social work support for the health services. The duty should also extend to the provision of nursing support.

Nursing support for local authority social services

5.52. Local health authorities employ nurses and health visitors in connection with their health functions and for the care of clients in their own homes and elsewhere. Health visitors and home nurses are normally on the staff of a Director of Nursing Services, and come within the area of responsibility of the Medical Officer of Health. On the re-organisation of the National Health Service they

will be transferred to the National Health Service: but, as the statement of nursing functions in Appendix E amply demonstrates, support, health guidance and provision of nursing skills will continue to be indispensable to the local authority social services.

5.53. Current policies are aimed at enabling people to remain in their own homes, or in residential accommodation, for as long as possible, and admitting them to hospital only when they need a nurse on call or require the diagnostic and treatment facilities that only a hospital can provide. We note that the age of admission to local authority accommodation for the elderly is rising, that new forms of medication are being prescribed, and that there is an increasing need for nursing care in local authority residential establishments. We nevertheless think that local authority homes should not assume a role where they become mere annexes to hospital geriatric or mental health units; and we hope that future policies will be directed at reducing the extent to which they fill this role at present. So far as possible, residents should receive nursing care on the same basis as if they were in their own homes. But on occasion a higher degree of nursing care may need to be provided on the premises, and medical assessment will need to be freely available, because the needs of individual residents for nursing care may vary from time to time, and should be kept under review.

5.54. Clients of the local authority in their own home or in residential accommodation remain under the care of their own general practitioners, and receive nursing care either through his or a health visitor's intervention. The care is normally provided by health visitors and home nurses. We have considered whether that care should in the future continue to be provided by nurses based in the employment of the local authority, as at present. But if the local authority employ their nurses after NHS reorganisation we see a danger that the nurses would become isolated from the mainstream of nursing; they could not receive adequate professional direction from within the local authority and there would be serious difficulties in maintaining their professional standards and keeping them up to date with new methods of treatment. We are therefore satisfied that the appropriate course is that nurses working in local authority establishments should be employed by the NHS. It should be a function of the AHA to provide the nursing and health support the local authority services need. The collaborative machinery, through the JCC, will be able to supervise the local arrangements. But we think it implicit in what we are proposing that a nursing officer at a senior management level in the AHA should be specifically responsible for nursing and health support to the matching local authority, and a clear point of contact for the local authority social services department. As already indicated in paragraph 5.51 we also think that a statutory obligation should be imposed on the AHA to provide support services for the local authority and that this should extend to nursing support.

5.55. It follows from what we have recommended that local authorities should, in our view, cease to advertise for and appoint nurses to work in their employment specifically on nursing duties in their residential establishments. They should look to the AHA both for advice on the need for nursing skill in these situations, and for the provision of qualified nursing staff to fill that need. We are aware that it is common practice for qualified nurses to be employed as wardens,

matrons etc. of residential establishments, and that in advertising such appointments local authorities often indicate that nursing qualifications would be an advantage. We think this is a situation to be distinguished from the employment of nurses as nurses. Possession of nursing skills and experience is an obvious advantage in many types of residential employment, and we do not think it necessary (or realistic) to seek to discourage this practice, which leads to people from a background of nursing working in a primarily administrative role, and not strictly in a nursing capacity.

Summary of conclusions on sharing professional skills

5.56. We have considered the main fields in which issues about the sharing of professional skills between AHAs and LAs arise. Taking this area of collaboration as a whole, our main conclusions can be summarised as follows:

5.56.1. The health and social services should rely on each other for the skills which each can best provide: social work skills should be based in local authority services and medical and nursing skills in AHA services.

5.56.2. Local authorities should assume responsibility for social work in hospitals. (We have recommended a series of safeguards, both for the hospital service and for the hospital social workers affected, summarised in paragraph 5.36.)

5.56.3. A statutory duty should be placed on local authorities to provide social work support for the health services and on AHAs to provide medical and nursing support for the local authority social services.

5.56.4. The management structure of both the AHA and the LA social services department should provide at a senior level for an officer to have special responsibility for the professional support which his service is to provide for the other. Thus, in the AHA there should be a senior medical and nursing officer with responsibility for ensuring the provision of, respectively, medical and nursing support to the LA: and in the LA there should be a senior officer in the social services department responsible to the Director of Social Services for ensuring the provision of social work support for hospitals.

5.56.5. Joint consultative committees should pay particular regard to arrangements for sharing of skills; in particular, they should set up standing sub-committees to supervise arrangements for social work in hospitals.

Collaboration and the voluntary sector

5.57. The important role of voluntary organisations and voluntary workers in the development of many services in the field of both health and local authority social services has frequently been stressed. The Seebohm Report emphasised that the maximum participation of individuals and groups in the community in the planning, organisation and provision of the social services was essential to the idea of a community based family service; and local authority social services departments make wide use of voluntary services.

5.58. In some instances, the voluntary organisations, particularly in the field of services for the blind, the handicapped and the deaf, undertake services as agents of the local authorities and receive reimbursement of their expenses. In the majority of cases, however, the voluntary organisations provide services which are complementary to those provided directly by the statutory authority, and receive financial support which varies considerably from one authority to another. In one or other of these ways, the social services departments are in direct contact with a large number of voluntary organisations. Some of these organisations act as co-ordinating bodies, such as old people's welfare committees or associations for the physically handicapped, and others, such as the WRVS or local associations for the elderly, provide services directly.

5.59. In most of the new social services departments, efforts have been made to co-ordinate the use made of voluntary services by appointing officers within the local teams with the specific duty to liaise with the existing voluntary organisations and to stimulate the development of new voluntary activities. This has led to an increasing number of individual volunteers working directly to the social services departments. In addition to this officer contact in the day to day provision of services, many authorities have also established at district level a forum or co-ordinating committee at which member representatives of the social services committee, the district authority and voluntary bodies can meet to discuss problems of common interest and promote understanding and co-operation. Local authorities commonly make grants to voluntary bodies for a variety of purposes.

5.60. In the hospitals also there has been a considerable development in recent years of use of voluntary assistance. Guidance from the Department has encouraged the extended use of voluntary organisations or volunteers, and given advice on their co-ordination as follows:

> "Responsibility for co-ordination should be placed upon the Group Secretary, or at hospital level upon the Hospital Secretary, or some other officer designated for the purpose. This officer will be closely in touch with the voluntary organisations, who may themselves do much of the work of co-ordination, selection, preparation and control of volunteers, but his function is to exercise control on behalf of the hospital. Some hospital authorities have appointed a paid organiser of voluntary services, usually full-time, to assess opportunities for and co-ordinate offers of voluntary service to the hospital and to exercise a special responsibility for the volunteer team. Experience has shown that such an appointment can be very valuable, especially in enlisting the services of those who wish to serve the hospital without joining any particular organisation. Such an appointment is, however, only one of the ways by which additional help can be obtained, and is unlikely to be appropriate for all authorities, some of whom have well tried arrangements with voluntary organisations which could be extended" (HM(69)58).

5.61. The White Paper: "Better Services for the Mentally Handicapped" (Cmnd 4683) dealt with the need for liaison in the use of voluntary help between hospitals and local authority social services departments, and suggested consideration of joint arrangements for voluntary service co-ordinators. As the

White Paper recognised, there is a risk of over-organising the voluntary field. At the same time, there are undoubted problems if the two services in effect compete with one another for voluntary assistance. And in a field where quite substantial sums of money may be involved in grants, we think it desirable that there should be a reasonable measure of co-ordination.

5.62. In such a diverse field it is difficult to recommend a single set of arrangements. Account has to be taken of bodies concerned with particular types of illness or disadvantage; of bodies whose principal activity is fund-raising; and of individual volunteers. We think, nevertheless, that it should be a concern of JCCs to review arrangements in their areas and develop them with the objective of ensuring that:

—overlapping demands on existing organisations are co-ordinated so that the organisations are used to the best advantage of the community;

—community resources of voluntary service are mobilised by joint effort to provide the maximum contribution to services;

—the contribution which voluntary organisations, in joint planning of services, can make is fully taken into account.

Ambulance services

5.63. The general question of collaboration in the sharing of common services does not fall to this sub-committee; but we were asked to consider the particular case of ambulance services, because this was an instance where the sharing arrangements were confined to the personal social services. Local authority ambulance services are used to take patients to hospital and to convey patients from hospitals to local authority day centres. In addition, many social services departments make use of sitting case vehicles to convey clients, such as the aged and handicapped, between their homes or residential accommodation and day centres. The cost of using ambulance vehicles in this way is charged to the social services. On the reorganisation of the National Health Service the local authority ambulance services would be incorporated into the unified structure of the health service. We have considered whether, following this transfer of responsibility for the ambulance services, any guidance should be given about the sharing of ambulance service vehicles by local authority social services departments.

5.64. The use of ambulance services by social services departments is widespread but not universal. Some departments make little or no use of ambulances and rely on other vehicles of the local authority or hire cars or coaches. We found that the number of ambulance vehicles available to social services departments, after providing for essential hospital duties and emergencies, varied between authorities and from day to day. We considered that it would be difficult to lay a requirement on health authorities to make vehicles available to social services departments without determining priorities for their use and that to do so would, in some cases, involve health authorities in additional expenditure. We therefore concluded that it should be left open to local discretion to examine the economics of different systems of transport and to decide the extent to which it would be convenient for local authorities to make use of the ambulance services.

It is clearly important that adequate transport should be available both to hospital patients and to local authority clients, and that no client or patient should be deprived of any service through the absence of transport facilities. We recommend that local authorities and the health service should co-ordinate their services so as to ensure a comprehensive transport service and, in particular, we think that the potentialities of the hospital car service could well be developed so as to provide transport for social services clients as well as hospital patients. This is a topic to which joint consultative committees might devote some attention.

CHAPTER 6

FIRST REPORT OF THE SUB-COMMITTEE ON THE SCHOOL HEALTH SERVICE—JULY 1972

The pattern of our report

6.1. The terms of reference of the sub-committee were never precisely defined but we started our work on the understanding that we should report on the collaborative arrangements to be introduced between the NHS and local education authorities if certain "School Health Service" responsibilities were transferred from reorganised local government to the reorganised National Health Service. Subsequently we widened our remit (see paragraph 6.3 below) to consider the implications of a decision to leave the "School Health Service" in toto with local government.

6.2. We have assumed that, except in London, local education authority (LEA) boundaries will be coterminous with those of the area health authorities to be established in a reorganised National Health Service.

6.3. In the course of our work we have identified certain questions to be considered and these have set the pattern both of our work and of this report:

—What do we mean by the "School Health Service"?
—Is it possible to identify any health responsibilities of the education authorities which should remain the responsibility of LEAs should the other health responsibilities be transferred to the NHS? And if so which?
—What are the considerations to be taken into account in forming a view on whatever future arrangements are devised for school health?
—What would be the implications of a decision to leave the school health service in toto with local government?
—On certain assumptions about a transfer of functions, what arrangements would be necessary to ensure satisfactory collaboration?
—What are the implications of our proposals for the child guidance service?

Scope of the report

6.4. In this, our first report, we confine ourselves to the major issues affecting the future of the school health service, and in particular those specifically identified by the local authority associations concerned in their views submitted in March 1971 (see paragraph 6.16 below). We have also confined this first report to the major issues which affect the work of the three main health professions—doctors, dentists and nurses. In a later report* we shall wish to comment on other related matters, and to go into greater detail on the implementation of our proposals, for example:

—the implications of our proposals for the employment of members of associated health professions—speech therapists, physiotherapists, occupational therapists, chiropodists, etc.;

* The second report of the school health service sub-committee, sent out for consultation in April 1973.

—any special considerations affecting the sharing of services;
—whether there are implications for student health;
—detailed discussion of arrangements for those parts of the service which will remain an LEA responsibility.

6.5. Questions of finance and of the application of our recommendations to London are under consideration by other sub-committees.

What do we mean by the "School Health Service"?

6.6. Since 1907, when the basis of those services which have become known as the school health service was first laid, there have been various major changes of emphasis in its functions. There is a generally higher standard of nutrition and physical care of children. There have been medical and scientific developments which have resulted in the virtual disappearance of some of the diseases and health problems of childhood, but which have created other problems both through the possibility of maintaining the life of the severely handicapped, and through increasing the potential of child development. There have been organisational changes; facilities for diagnosis and treatment have become generally available through the NHS, and medical and scientific developments have carried with them requirements for greater specialisation and also for greater co-operation between services.

6.7. The primary function of the school health service has always been to promote the health and well-being of schoolchildren. These aims are embodied in section 48 of the Education Act 1944, which requires local education authorities to provide for the medical inspection of school children, to ensure that free treatment is available by providing this themselves if necessary, and to assist children to avail themselves of treatment facilities. But the present school health service is far more than a service of inspection followed by such treatment as it is necessary for the LEA to provide outside the framework of the NHS. To some extent indeed the routine overall inspection and treatment elements are receding in importance. There is greater concentration on selectivity, and on anticipating and advising about the health problems of individual children, the implications these may have in an educational setting and on the medical aspects of the education of handicapped children. We have identified certain essential features:

6.7.1. The co-operation and partnership at administrative and personal level between health and education staff—and the continued and increasing need for such co-operation between heads of schools and teachers and doctors, dentists, nurses, and other health care staff over the behavioural and health education aspects of school life.

6.7.2. The advantage for the education service of the health staff understanding the school setting and the problems of child development within the school environment.

6.7.3. The inter-relationship of the various elements of what is now contained within the school health service, whether this is work which strictly flows from the provisions of section 48, or is related to other statutory provisions, or indeed which may have developed without specific statutory provision.

6.8. We emphasise these features of the service so that the attempt which we make in subsequent paragraphs to look at the individual elements contained within the service shall be seen within this context of collaboration and inter-relationship.

6.9. We have considered the work undertaken by the school health service and a detailed account of this is set out in the memorandum at Appendix F. We summarise below the sources from which the work flows, but we would emphasise that individuals may not be involved in all of the work, and that the actual work of individuals cannot be as easily separated as the sources of the work. The knowledge, for example, which a school medical officer obtains as a result of general medical oversight may also be used in advice which may be given about the need for special education, or at a later stage about possible employment difficulties. In a real sense, therefore, the school health service can be taken as comprising all those educational functions to which the health professions contribute. The sources of the work undertaken by the school health service, thus defined, are:

6.9.1. *Section* 48 *of the Education Act* 1944 (as amended by the Education Act 1953, section 4). This provides for medical and dental inspections, for the various screening examinations, for the oversight of individual children and the advice which may be given to their parents, and in the case of elder pupils, to the pupils themselves. It enables LEAs to provide clinics, and in various ways to help pupils to take advantage of NHS facilities, or to supplement these facilities.

6.9.2. *Sections* 33 *and* 34 *of the Education Act* 1944. Under these sections LEAs provide for the special education of handicapped children and ascertain whether pupils require special education. In carrying out these functions they need advice from medical and other health service staff and may also require the services of nursing, and physiotherapy and other para-medical staff in their special schools or in dealing with handicapped children in ordinary schools.

6.9.3. *Health education in schools.* The responsibility for health education within the school curriculum rests with the education service. The co-operation of school medical and dental officers and nurses may be required in presenting health education topics, and in the counselling of individual pupils (and their parents) over health education matters.

6.9.4. *Advice on the health and "physical capacity" of teachers and entrants to teacher training.* Regulations require that colleges of education have to be satisfied about entrants' good health and physical capacity for teaching. In practice advice about this is usually provided by school medical officers. Regulations also provide that the Secretary of State shall be satisfied about health and physical capacity for teaching before a teacher is first employed. LEAs will require advice about teachers' health in their role as employers, and advice may also be required by the Secretary of State if there is doubt on medical grounds about a teacher's continued employment. In all cases the question of suitability for employment has to be considered not only from the

point of view of the individual teacher but also in relation to the welfare of the pupils for whom they are responsible.

6.9.5. *LEA's general managerial responsibilities* for environmental hygiene and safety in maintained schools and establishments of further education.

6.9.6. *Reports or action required by statute.*

6.9.6.1. *Section* 54 *of the Education Act* 1944 which empowers the education authority to authorise a medical officer to see that children who are verminous etc. are examined and to ensure that appropriate action is taken.

6.9.6.2. *Section* 59 *of the Education Act* 1944 and local bye-laws which provide that a pupil shall not be employed in a manner prejudicial to his health or otherwise to render him unfit to obtain the full benefit of the education provided for him. The LEA may ask for the advice of medical officers about individual children.

6.9.6.3. *Section* 1(i)(b) *of the Education* (*Milk*) *Act* 1971 which provides for milk to be provided on the advice of a school medical officer.

6.9.6.4. *The Disabled Persons* (*Employment*) *Act and Section* 1(6) *of the Employment Medical Advisory Service Act* 1972. The school medical officer supplies information (on Forms Y10 or Y9) to the careers officer about handicapped school leavers and those who may not be suitable for certain specified employment. If requested by the employment medical adviser the school medical officer has a duty to provide medical information relevant to a pupil's employment.

In carrying out their responsibilities to provide some of these reports medical officers may make use of school medical records and knowledge they have gained through their general medical oversight of school pupils and will not need to examine all pupils.

The assumptions about transfer of responsibilities

6.10. In broad terms we have assumed that a transfer of responsibility would in effect involve those duties of LEAs which fall to them under the Education Act 1944, section 48 (as amended by the Education Act 1953, section 4) although provision might be required for LEAs to continue to carry out certain of the functions now provided under section 48(3) and (4). This question is referred to later (paragraphs 6.47–6.50). LEAs would continue to be responsible for special education and the functions which fall under 6.9.3, 6.9.4 and 6.9.5 above. Responsibility for those falling under 6.9.6 will be considered later, and will be the subject of a further report.

What are the considerations affecting a decision on the future of the "School Health Service"?

6.11. Before setting these out we must make what may be an obvious point, but is none the less of great significance—we are not here concerned with a choice between change and the status quo. Subject to Parliament, the bulk of local government health responsibilities will become part of an integrated NHS on

1 April 1974. The matter with which the sub-committee has been concerned relates therefore to the question whether the school health service (as delimited in paragraph 6.9 above) should be transferred to the NHS and what arrangements would be needed to achieve this satisfactorily, or whether the service should remain in toto the directly administered responsibility of LEAs.

6.12. There are two important groups of considerations. The first concerns the functioning of the school health service from the point of view of the LEA and of school teaching staff. Both the authority and the staff are concerned for the preservation and further development of the present partnership, and to maintain a relationship with individual doctors, nurses and other staff, to whom they, and their pupils and their parents, can turn with ease and confidence. They are concerned that the value of the service shall be fully recognised and sufficient resources devoted to it, and also that the medical and other staff shall continue to see themselves as part of the team responsible with the education service for trying to provide the best opportunity for each individual child. LEAs and teachers want the medical and other staff who advise them to be able to indicate the significance for work in schools of medical developments in child health and the care of handicapped children, and hope that they will also be able to bring a knowledge of the school environment to their medical colleagues in other spheres.

6.13. The second set of considerations concerns the relationship of the school health service, and of the school medical officer, to the rest of the NHS. At present there is close co-operation between the services for children under 5 and those of school age, usually under a joint Medical Officer of Health/Principal School Medical Officer. The child is a single developing person from birth to maturity. Not only is it desirable that a total view shall be taken of child health, but it is also highly probable that those who are interested in the health care of children will want to be able to work with children of all ages, as indeed the many medical officers who are jointly employed by local health authorities and LEAs do at present. The health provision within the school, moreover, is only a part of the total health services deployed in the furtherance of the better health of the school child (the general practitioner and hospital services contribute substantially to this concern). Those responsible for the health of school children will want to feel themselves an integral part of the composite health care teams of the NHS, and close relationships between the hospital, GP and school health services are likely to be that much easier to maintain if all are part of one service.

6.14. We have to set these considerations against our judgment on which of the alternative patterns of co-operation is more likely to ensure that right decisions are taken and implemented about the allocation of resources of money and manpower for child health. At present these decisions are taken and implemented partly within local government and partly outside it, thus:

Education services Local health authority services for children School health services	Local government
Family practitioner services	
Hospitals, by HMCs BGs and RHBs	

It is not suggested that decisions are now taken in isolation from each other, but there is no clear framework in which joint co-operation can flourish. In the future there will be a framework which will embrace the local health authority services for children, the family practitioner services, and hospital provision for children, and the question is whether the organisation and development of future health services for school children will be best facilitated by a separate school health service, i.e. by the health services remaining with local government, or by it becoming a direct responsibility of the NHS.

A separate school health service

6.15. We have given careful consideration to what would be involved in leaving the totality of the school health service responsibilities with LEAs, that is to say with making no amendment to the 1944 Act. We recognise that there are likely to be very serious practical difficulties, and believe that not even the biggest education authorities would be able to maintain and develop a fully effective school health service apart from the main body of the health services of the country, nor do we think it would provide a satisfactory career structure for doctors of ability in the school health service to be cut off from developments in paediatrics and child health. We believe that it is crucial to remember in considering this issue that it is the intention that as from April 1974 there should be an integrated health service. We do not think that it would be desirable for the furtherance of the health of children that the responsibility for the health of children receiving ordinary education should be divided between two Authorities, given of course that it is accepted that educational needs are taken fully and properly into account in determining the provision of services for children generally in school and out of it.

Arrangements for collaboration on the assumption of a transfer of responsibilities

6.16. In their joint memorandum of March 1971 (Appendix H) the local authority associations concerned with education submitted that "special consideration will be needed as to arrangements for:

—determining policies, e.g. by arranging for the submission of agreed proposals to the appropriate Government Departments for confirmation;

—resolving differences as to policies and priorities as between area health and local authorities;

—finance, as between area health and local authorities;

—ensuring acceptable performance of agreed policies, e.g. suitable default provisions;

—ensuring adequate involvement in matters of joint concern, including appointments; and

—encouraging close working relationships of the kind which exist at present between school medical officers and the teaching staff of the schools."

In addition the associations stressed "the importance they attach to the need to ensure that the contribution, both direct and indirect, made by the school health service to the education process is encouraged to continue to develop and to

reverse any tendency for the service to run down as a result of uncertainty as to the future; in the opinion of the associations, the dissipation of the enthusiasm and skills which have been built up in the school health service, particularly over the past 20 years, would constitute an incalculable loss to education and the country's health."

6.17. We have considered various organisational arrangements which should achieve what the associations seek. Those which we recommend in the following paragraphs 6.19–6.43 as being necessary to meld educational and health requirements involve—

6.17.1. Overall statutory obligations on the AHAs and LEAs.

6.17.2. The availability of medical and health advice to the LEA.

6.17.3. Joint consultative machinery.

6.17.4. Joint oversight of the implementation of plans.

6.17.5. Arrangements for day to day working.

6.18. Finally, we recognise that no system of collaboration will be effective unless there is general agreement about the long-term needs of child health and school health, including the training and career patterns of the staff, and we recommend that a review be undertaken to this end as a matter of urgency.

The overall statutory position

6.19. We understand that it would be technically sufficient for the NHS to exercise statutory responsibilities *vis à vis* school health on the basis of general references in legislation to the provision of health services, i.e. without a specific reference to school health. WE RECOMMEND however that the importance of school health is such that this duty should be described more specifically, i.e. in terms analogous to the appropriate provisions in section 48 of the Education Act 1944.

6.20. WE RECOMMEND moreover that, to assist in carrying out the functions of the LEA which require the involvement of health related services, e.g. sections 33 and 34 of the 1944 Act, it should be required by statute that the NHS should provide staff, services and equipment and should make available to local authorities suitably experienced registered medical practitioners; that LEAs should be required to provide appropriate accommodation and reasonable facilities within their premises for the operation of these services by the NHS; and that, in these arrangements, the LEAs and the NHS should co-operate with one another in order to secure and advance the health and welfare of the people.

Advice to LEAs

6.21. LEAs will need medical advice both on the implications of health proposals on the education services for which they are responsible and for their functions which are related to health and in which they need the co-operation of the NHS. The usual pattern under present arrangements is for the Principal

School Medical Officer to be the Medical Officer of Health (MOH), with a full-time deputy or senior medical colleagues responsible for school health. We do not envisage an exact replica of this in all circumstances in the new situation; but WE RECOMMEND that a senior doctor with appropriate experience and training should be appointed, in agreement with the matching LEA, in each AHA at AHA level. He or she would carry the advisory and co-ordinating responsibility for child health as a whole, would have both advisory and executive responsibility for the transferred school health service and give general medical advice to the LEAs. It will not of course be enough simply to make an appointment of this kind without identifying the fact that the doctor thus appointed will have responsibilities and loyalities to the LEA as well as to the NHS. The manner of this appointment (i.e. being with the agreement of the LEA) will determine this to a considerable extent. Both the doctor thus appointed and the LEA will have rights and duties. The LEA will have the right to expect advice from this senior doctor, that he or she should attend appropriate meetings of its committees and give advice on the points raised by them, and should have a duty to ensure that he or she gets the necessary help and co-operation to enable him or her to carry out its functions. Similarly the doctor thus appointed will have duties to the LEA in respect of the advice which he is to give them, and the right also to report and comment on the health implications of education decisions.

6.22. The Area Dental Officer will have a general co-ordinating responsibility to the AHA for all dental services in hospitals, for school children and for the priority dental service for mothers and young children and a responsibility for liaison with general dental practitioner services. He or she will have executive responsibility for planning and organising the dental services for school children in the area, in consultation with officers of the LEA, and also the priority dental services for expectant and nursing mothers and young children. There will be district dental officers responsible to the Area Dental Officer. There will need to be a statutory requirement for the LEA to provide accommodation within their premises (and access to them) for the school dental service as for other functions exercised by the NHS (see paragraph 6.20 above). The Area Dental Officer will have a right and duty to the LEA to attend appropriate meetings of committees and to give advice on dental matters.

6.23. The Area Nursing Officer will have a responsibility for school nursing services through a district nursing officer. A senior nurse on her staff will have special advisory and co-ordinating responsibilities for child health, including the school nursing service. The senior doctor responsible for the child health service and school health service for the area (see paragraph 6.21 above) will look to this nursing officer as his point of contact and we envisage that the Area Nursing Officer and the senior nurse with special responsibilities for child health will be in close contact, both in planning services and in day to day working, with the senior doctor who has responsibility for the child health and the school health services, with the community physician of the health service district, and with officers of the LEA. We envisage that the district nursing officer will have a nursing officer on her staff who will work alongside the district community physician on school health questions. She will be a point of contact on day to day matters for head teachers. The nursing staff will be part of a multi-disciplinary team serving the schools, an arrangement which has not hitherto proved possible.

Joint consultation

6.24. Some local government members will be appointed to each AHA, and will have local interests in mind. We believe that closeness of working together in practice would be enhanced if members of the AHA were co-opted to the appropriate committee or sub-committee and WE RECOMMEND that the desirability of this should be brought to the attention of LEAs.

6.25. The appointment of a senior doctor on the lines recommended in the previous section, and the arrangements for the deployment of dentists and nurses, should do much to ensure close working between LEAs and AHAs, but those responsible on the health side will not be in a position to ensure that the educational needs are taken fully into account; and in the following paragraphs we discuss arrangements for collaboration between the two authorities.

6.26. The two authorities will rely largely on the advice of the senior school/child health doctor to whom we have referred, but at officer level the machinery for collaboration will be the responsibility of the chief officers. In large measure, co-operation between officers should be sufficient. But WE RECOMMEND that a joint consultative committee should be established in each area, composed of members appointed to the two authorities, and that this should be required by statute. We do not think it is necessary to lay down by statute the terms of reference and composition of such a committee, but authorities may welcome guidance on this in due course.

6.27. The matters to which this joint consultative committee should turn its attention would include, for example:

Planning jointly the provision of staff and services and of capital plans.
Determining priorities.
Supervising the achievement of plans.
Considering the adequacy of the provision made, on the basis of plans and on an assessment of their achievement.
Ensuring that there are systems of co-operation between officers of the two authorities, and that they work.

6.28. The functions of these committees would be to examine jointly the needs of each area, the plans of the two sets of authorities for meeting those needs, and the progress made towards meeting them; and to advise on both the planning and the operation of the services in matters of common concern. The objective would be to secure genuinely collaborative methods of working throughout.

6.29. We do not of course suggest that all the plans of the two authorities should be submitted to the joint consultative committee. But the officers servicing the committee (who would be officers of the two authorities appointed for the purpose) would prepare joint plans in respect of all the forward activities of the two authorities which impinged upon each other (examples would be plans for the deployment of doctors and nurses in the furtherance of school/child health and the development of screening and assessment facilities; and plans for the building of a special school which would have implications for the health staff and facilities required). The officers attending meetings of the joint consultative committee should include the Area Dental Officer and the Area Nursing Officer.

6.30. Neither the joint consultative committee nor its secretaries could be given executive powers without detracting from the responsibilities of the two authorities; and we are convinced that this would be unacceptable. We understand that it is likely to be a part of the management arrangements within the NHS that endorsement of the broad strategy implied in AHA plans should not be given without confirmation that they have been considered with local authority plans. We are moreover confident that the views of a joint consultative committee of this kind will carry very considerable weight with the two authorities.

6.31. We recognise that there may be occasions on which there will be genuine and serious differences of opinion about priorities and plans between those representing each authority on the joint consultative committee, and that these differences of opinion on occasion might not be adequately resolved. There are many ways in which either authority can bring these differences of opinion to a discussion in a wider forum, either by reference to central government or to public discussion. And given the arrangements for collaboration which we recommend we do not think it necessary that there should be any formal right of appeal from either authority to central government.

6.32. The recommendations of the joint consultative committee to its parent authorities should be made known to the public and the press in some suitable manner. The parent authorities should also report periodically to the Secretary of State on how the joint consultative committee is working.

6.33. The greater part of the joint consultative process will involve the interaction of NHS and LEA activities at AHA level. There may develop a need to consider the planning of facilities either on a (health) regional basis or as affecting more than one LEA. We do not think there is any need to set up formal machinery for this, and suggest that it may be appropriate for such matters to be discussed by the appropriate groups of AHAs and LEAs. (The regional health authority would presumably wish to be involved in these discussions—indeed the RHA might wish to appoint a member or observer on the joint consultative committee.)

6.34. If similar joint consultative committee arrangements are regarded as suitable to oversee joint working between the NHS and local government social service departments, we would think it desirable that a single joint consultative committee should be established to cover all local authority/AHA relationships, including, where appropriate, environmental health. We recognise that such a committee would need to set up sub-committees (e.g. health/education; health/social services).

6.35. We do not think it right to seek to lay down the composition of such committees or their manner of working; we do however regard it as one of the first and most important tasks of such a committee to determine its procedures and to agree the standing orders under which it is to operate.

Implementation of plans

6.36. We envisage the joint consultative committee as being the forum in which either authority could raise questions of failure to implement plans such as could not be settled between officers referring to their respective authorities.

Employment of nurses in schools

6.37. We have considered the arrangements appropriate for the appointment and employment of nurses in schools, both ordinary and special schools: we would hope that nursing staff employed in schools would be provided by the AHA through the collaborative arrangements we have outlined. We regard it as important that these nurses should remain within the mainstream of their profession and have available to them the career development and training arrangements provided by the AHA. We also recognise that the nurse employed within the special school is an integral part of the special education team; we would expect that in future training arrangements would have regard to this and that the AHA would recognise the importance of stability in the nursing support for special schools. We also envisage that AHAs and LEAs may wish to come to an agreement about employment on the basis of secondment to the LEA. The career development of the nursing staff would then lie within the AHA but at the same time the LEA would be able, subject to professional requirements, to determine the work required of the nurse who would be accountable to the education authority for discharging her duties and for her general conduct.

Arrangements for day to day working

6.38. The crucial aspect of these arrangements as they affect the doctor, dentist or nurse working in the field of school health is that they should feel themselves involved in the educational process. They must see their loyalties as being both to the LEA and to the AHA. Their training and the careers which will be open to them must support their feeling of involvement with the educational system.

6.39. We have considered what formal arrangements should be made for the submission of requests by a head teacher for significant changes in the provision of health services for his school, and WE RECOMMEND that requests of this kind should always be submitted to the Chief Education Officer who would forward them, if approved, to the AHA. This should not however prevent a sensible and informal link between head teacher and, say, school doctor, by which the latter would do what he could for the school within his own competence. And no doubt in developing arrangements, the Chief Education Officer will encourage the maintenance of informal links between head teachers and those responsible for the school health service at all levels.

6.40. We recognise moreover that head teachers will wish to maintain their close and continuing links with doctors, dentists, nurses and health administrators. These links will be of two kinds, clinical and administrative. In respect of clinical links head teachers will wish to be sure that the doctor, dentist or nurse who are given the task of concerning themselves with "their" school will be available to them for a reasonable period. The responsible authority within the NHS should regard it as a major requirement that this close working should be maintained. For administrative links head teachers will either look to a doctor, dentist, nurse or administrator at area level or, where there are health service districts, they will look to the district community physician (and the dentist and nurse at district level) who will be working and accountable within agreed policies at area level.

6.41. It will be one of the most important and continuing tasks of the joint consultative committee to ensure that such close working links are forged and maintained.

Future needs of school health

6.42. No arrangements for co-operation in the provision of services are likely to be effective unless there is general agreement about the long term aim, i.e. what level of services is necessary and how this should be attained. It has seemed to us therefore that, both to satisfy LEAs generally that their needs are fully understood, and also to provide an agreed policy framework in which future joint planning by AHAs and LEAs can develop, it is important that there should be an early review of the future needs of child/school health with a view to determining an agreed policy. Such a review should be concerned both with the needs of child/school health, and with the other LEA needs for health related services, such as are described in paragraph 6.9.2–6.9.5 above. Reference to the need for a review prompts us to comment that, in the course of our discussions, we have been aware of the very considerable degree of anxiety felt in the school health service and the education service as a whole about the future role and scope of the service, and the ways in which the education service can be enabled to continue to draw on the help and advice of the health professions. We have been concerned with the structure for collaboration, and for the future of the service inside or outside the NHS. It might have been more appropriate to review the future of the service before deciding upon its structure, but we understand the need for structural issues to be settled quickly. That said, however, we believe that it is equally important to press ahead with consideration of future needs, and we hope that the review to be undertaken of these needs will be pressed ahead with the utmost urgency.

6.43. We are not competent ourselves to undertake such a review. But WE RECOMMEND that such a review be undertaken and that this should take into account the views of all the interests concerned, the health and education professions, local government, and DHSS, DES and the Welsh Office. We anticipate that such a review would have much to say about training and a career structure for the staff working in the school health and child health service.

6.44. We have noted that the Working Party on Medical Administrators (Hunter)* have considered and made recommendations on the role of the specialist in community medicine, which in many instances support those of our recommendations which deal with the organisation of the child health/school health service in 1974. The role of clinicians in the school health service did not, however, fall within their terms of reference. Nevertheless, paragraphs 74 and 75 of the Hunter Report deal with the importance of the continuation of this group of doctors and the organisation of their work by the AHA, and paragraph 138 stresses the need to reassure these doctors, i.e. that an early Government statement should be made clarifying their continuing future role as clinicians within the reorganised NHS. We agree with this and recommend that the clinicians,

* The Report of the Working Party on Medical Administrators (HMSO 1972).

both doctors and dentists, in the school health service should be transferred as a group to the staff of the AHA to enable them to continue in, and further develop, their present fields of work. We are conscious of the anxieties of this group of doctors and dentists and further recommend that their position within the reorganised NHS should be clarified as soon as possible.

Implications of our proposals for the child guidance service

6.45. We have considered information about possible future trends in the organisation of the child guidance service and have taken note of the fact that section 48(3) of the Education Act 1944 is held to provide a partial basis for arrangements made by LEAs for the provision of child guidance. We understand that the trend is likely to be towards each of the specialties making up the child guidance service working from their professional bases; that is, child psychiatry is increasingly based on general hospitals, social work has its main base in local authority social services departments, while educational psychology will continue to be based in local education authorities. The present pattern of organisation may change, but it will continue to be essential that there should be close co-ordination and co-operation between these three services. We are informed that there will be consultation in due course with those concerned about any detailed guidance in relation to child guidance services. We would however wish to comment that whilst we recognise that there may be changes in organisation we would not want LEAs' present powers in relation to the provision of child guidance to be in any way limited as a consequence of legislative changes to give effect to our recommendation in paragraph 6.19.

Conclusion, on the implications of a transfer

6.46. We believe that the proposals which we have described in paragraphs 6.19–6.44 above will satisfy the HEALTH considerations which we have described, i.e. the need to see child and school health as a whole, providing a service situation in which staff of all the health professions will be happy to serve. Whether or not it can be said to satisfy EDUCATIONAL needs must be looked at in relation to the desiderata which the local authority associations set out in their memorandum of March 1971 (Appendix H) from which paragraph 6.16 above quotes. Our overall strategy to meet these desiderata can be summarised as follows:

6.46.1. We recommend a statutory obligation on the NHS, on the lines of the Education Act 1944, section 48, and a statutory obligation to provide the necessary services to assist the LEAs to carry out their health related functions (paragraphs 6.19–6.20). Recognising, however, that it provides no more than a skeletal structure on which we must put firm flesh—

6.46.2. We recognise that no system of co-operation will work properly unless it is based on a common understanding of the agreed aims to be achieved and we recommend therefore an early review of future child/school health needs and the determination of an agreed policy thereto (paragraphs 6.42–6.43).

6.46.3. We recommend that the matching authorities at AHA/LEA level should be required by statute to establish a joint consultative committee, which would not itself have executive power but which would serve as a forum for planning and consultation (paragraphs 6.26–6.35).

6.46.4. We recommend that failure to implement agreed plans should also be discussed in the joint consultative committee (paragraph 6.36).

6.46.5. We recommend that LEAs be advised of the desirability of co-opting AHA members to the appropriate committee or sub-committee (paragraph 6.24).

6.46.6. We recognise that LEAs may be at a disadvantage in the joint consultative committees if they do not have professional advice on which they can lean; and we recommend that a senior doctor responsible for school/child health should be appointed by each AHA in agreement with the matching LEA, whose responsibility it would be to give independent advice to both the AHA and the LEA, with similar arrangements for dental and nursing services (paragraphs 6.21–6.23).

6.46.7. It would be for those thus made responsible to ensure that the staff working in the school environment would understand their responsibility to the school and to the child. We believe furthermore that the close integration of all those working together for the furtherance of the health of children in an educational context will be a prime responsibility of the proposed joint consultative committee (paragraphs 6.38–6.41).

Conclusions

6.47. We are agreed that if the transfer of responsibility as proposed is to take place we would recommend collaborative arrangements between the education service and the reorganised NHS as set out in paragraphs 6.19–6.45 and as summarised in paragraph 6.46 above.

6.48. How these arrangements would work out in practice would depend firstly on the priority which the AHA are able to give to child health and secondly on a high degree of co-operation at all levels between the NHS and the LEA.

6.49. Education authorities have responsibility for children whose educational progress may be being hindered for medical reasons; they will want to be assured beyond question of sufficient medical support and services, if necessary at short notice, to tackle the problems of individual children before they become acute. We are clear that whatever statutory provision is made in future it should not in any way inhibit the provision of necessary services by local education authorities. We have considered what powers we should recommend should remain with, or be given to, LEAs to ensure that, if it is essential to do so, they can supplement the general health provision, after prior consultation with the AHA so as to secure the efficient running of the services for which they are responsible.

6.50. We have considered whether powers are needed which would go further than this and would in effect enable an education authority to provide a full medical and dental inspection service for children in the schools. Some of us, noting the expressed intention that in a reorganised NHS the importance of preventive medicine is to be enhanced, are confident that such blanket overall powers will not in any case be necessary, and those of us who do not have this complete confidence nevertheless do not believe it to be in the long term interests of child health that there should be any doubt as to where responsibility for child health services should lie; nor do we think it likely that an education authority would in practice be able to recruit the professional staff required for a separate school health service which would be an appendage to a comprehensive service provided by the NHS in the future. Conversely, there should be no doubt about where responsibility for meeting the educational needs of individual children should lie. We believe that the normal requirements of local education authorities for medical help and advice in dealing with the needs of individual children (e.g. for the purposes of the Education Act 1944, sections 33 and 34) will be met as an integral part of the future child health services, but we would none the less wish to recommend that future legislation should not prevent local education authorities from making direct arrangements in exceptional cases where educational needs make this necessary.

6.51. A note of dissent by Sir William Alexander, Mr D Andrew Davies and Mr Graham Turner follows immediately.

Note of dissent by Sir William Alexander, Mr D Andrew Davies and Mr G Turner*

6.52. We regret that we find it necessary to record a note of dissent from the concluding section of the report. We wish to make it clear that on the assumption of the transfer as set out in the report we accept that the arrangements proposed for co-operation are as good as can be made. Our dissent, therefore, is not from the main body of the report but from the concluding section only.

6.53. We feel that there are reasonable doubts both as to the degree of priority which the NHS will be able to accord to the school health service and as to whether in all areas the high degree of co-operation required will be obtained.

6.54. We recognise that while provision is made for joint consultation no provision is made for the resolution of differences of opinion which might occur between those representing the local authorities and those representing the NHS on the joint consultative committee, other than apparently an appeal to public opinion or to central government. For the last two decades the fact that there were concurrent powers both in the NHS and in the local education authority service has in very many cases avoided difficulties and secured the provision of services which the local education authorities regarded as essential but which the NHS was unable to provide. We have, therefore, reached the conclusion that the most effective way of securing that such difficulties can be resolved in future is to maintain the principle of concurrent powers.

* A list of members of the Sub-Committee can be found in Appendix A.

6.55. It may be that the arrangements set out in the report will prove to be so completely successful that the provision which we propose will rarely, if ever, have to be exercised, but we think it essential that this provision should be made. There is one other factor that is important. Without such provision, if an LEA found it necessary to incur any expenditure on a matter on which they did not have a statutory duty or power they could be charged with illegal expenditure. This is a situation which we think it imperative to avoid. Accordingly, we propose that the conclusion should embody the two paragraphs which we set out below, the first expressing our very real concern and the second providing a solution to difficulties which might arise:

"We recognise that under the arrangements set out in this report the maintenance and development of the school health service rests on two fundamental assumptions about which doubts could reasonably be expressed, first the degree of priority which will be accorded to the school health service by the AHA and, secondly, the high degree of co-operation which will be required between the NHS and the LEA at all levels.

"Recognising these doubts, we recommend that provision be made that, where an LEA is satisfied that adequate provision is not being made for the school health service, the LEA may make such appointments and incur such expenditure as are necessary for the maintenance of an adequate school health service (as provided in the Education Act 1944); and such expenditure shall be recognised as relevant expenditure in the education account for the purposes of Rate Support Grant."

APPENDIX A (Chapter 1)

WORKING PARTY ON COLLABORATION—MEMBERS

MR A R W BAVIN (Chairman)	Department of Health and Social Security
SIR WILLIAM ALEXANDER	Association of Education Committees
MR G C BATESON	Secretary, East Liverpool University Hospital Management Committee
MR E M BIRTWISLE	Chief Public Health Inspector, Horsforth Urban District Council
MR W BOYCE	Director of Social Services, Essex County Council
MR A J CARR	Chief Nursing Officer, Central Wirral Hospital Management Committee
DR E COLIN-RUSS	General Practitioner, London
MR D ANDREW DAVIES	Secretary, Welsh Joint Education Committee
MR L J DREW	Director of Education, Swansea County Borough
DR R W ELLIOTT	County Medical Officer, West Riding County Council
MR R ELLIS	House Governor and Secretary, St George's Hospital
MR D M FLEET	Director of Social Services, London Borough of Tower Hamlets
MR J H GARDHAM	Director of Social Services, City and County of Kingston upon Hull
DR F HAMPSON	Area Pathologist, Royal Berkshire Hospital
DR R E A S HANSEN	Medical Officer of Health, Thornbury Rural District Council
DR W G HARDING	Medical Officer of Health, London Borough of Camden
PROFESSOR W W HOLLAND	Department of Clinical Epidemiology and Social Medicine, St Thomas' Hospital Medical School
MR W L HOOPER	Assistant Director-General, Greater London Council
MR W O JOLLIFFE	Treasurer, Blackpool County Borough
MR W E LANE	Clerk and Clerk of the Peace, Parts of Lindsey County Council
MISS A O PENNEY	Chief Nursing Officer, Surrey County Council
DR J R PRESTON	Medical Officer of Health, Sutton Coldfield Borough Council
DR W G A RIDDLE	General Practitioner, Gateshead
MR S H A SHAW	Clerk of the Executive Council for Essex
DR A B STEWART	Medical Advisor, Inner London Education Authority

DR I B SUTHERLAND	Senior Administrative Medical Officer, South Western Regional Hospital Board
MR R W J TRIDGELL	Chief Executive and Clerk of the Council, Crawley Urban District Council
MR F DIXON WARD	Chief Executive, London Borough of Lambeth
DR J WEDGWOOD	Consultant Physician in Geriatrics, The Middlesex Hospital
MR G H WESTON	Secretary, North West Metropolitan Regional Hospital Board

Departmental Members:

DR R T BEVAN	Welsh Office
MR R A OWEN (resigned 1.12.72)	Welsh Office
MR R HALL WILLIAMS (appointed 1.12.72)	Welsh Office
MR J E HANNIGAN (resigned 4.12.72)	Department of the Environment
MR D C MILEFANTI (appointed 4.12.72)	Department of the Environment
DR E SIMPSON	Department of Education and Science
MR P SLOMAN	Department of Education and Science
MRS D M WHITE	Department of Education and Science
DR F D BEDDARD (appointed 23.10.72)	Department of Health and Social Security
MR B H BETTS	Department of Health and Social Security
MR J P CASHMAN	Department of Health and Social Security
MR A J COLLIER	Department of Health and Social Security
MR J P DODDS	Department of Health and Social Security
MRS J M FIRTH	Department of Health and Social Security
MISS H M HEDLEY (appointed 4.12.72)	Department of Health and Social Security
MISS A M LAMB	Department of Health and Social Security
MR G J OTTON	Department of Health and Social Security
DR R M SHAW (resigned 23.10.72)	Department of Health and Social Security
MISS A M SHERIDAN	Department of Health and Social Security
DR J T JONES	Department of Health and Social Security

Secretary:

MISS R D B PEASE	Department of Health and Social Security

Observers:

MR C J BERRY (appointed 26.10.72)	Association of Municipal Corporations
MR W H HOPKIN (resigned 26.10.72)	Association of Municipal Corporations
MR T A NELSON	County Councils Association

School Health Service Sub-Committee:

MR A J COLLIER (Chairman)	DR R T BEVAN
SIR WILLIAM ALEXANDER	MR G F COCKERILL (appointed 23.5.72)
MR A J CARR	MR D ANDREW DAVIES
DR E COLIN-RUSS	MR D M FLEET
MR L J DREW	DR W G HARDING
MR G D GIBB	MISS A M LAMB
DR J T JONES	MR P V MUSTON
MR E L MAYSTON	MISS A O PENNEY
MISS R D B PEASE	DR E SIMPSON
DR E M RING	MRS D M WHITE
MR P SLOMAN (resigned 23.5.72)	

**Co-opted Members:*

*DR H O M BRYANT	Medical Officer of Health, West Bromwich County Borough
*PROFESSOR J A DAVIS	Department of Child Health, Manchester University
*MR J W HENRY	Chief Education Officer, Surrey County Council
*DR H I LOCKETT	County Medical Officer, Nottinghamshire County Council
*MR G TURNER	Principal School Dental Officer, City of York
*DR G S WIGLEY	Deputy Medical Adviser, Inner London Education Authority

Secretary:

MISS M F P BOYS	Department of Health and Social Security

Assistant Secretary:

MR K A SMITH (resigned 11.12.72)	Department of Education and Science
MISS W E MOLD (appointed 11.12.72)	Department of Education and Science

Observers:

MR C J BERRY (appointed 26.10.72)	Association of Municipal Corporations
MR W H HOPKIN (resigned 26.10.72)	Association of Municipal Corporations
MR T A NELSON	County Councils Association

Health and Social Services Sub-Committee:

MR G J OTTON (Chairman)	
MR W E BOYCE	MR S H A SHAW
MR A J COLLIER	DR I B SUTHERLAND
MR R ELLIS	DR J WEDGWOOD
MR D M FLEET	MRS J M FIRTH

MR J H GARDHAM	DR J T JONES
DR W G HARDING	MISS A M LAMB
PROFESSOR W W HOLLAND	MR R A OWEN
MISS A O PENNEY	MISS A M SHERIDAN
DR W G RIDDLE	MISS R D B PEASE
	DR E SIMPSON

**Co-opted Members:*

*MR K A ABEL	Clerk of the Peace and Clerk of the Dorset County Council
*MR J H ALDAM	County Education Officer for Hampshire County Council
*DR T H D ARIE	Consultant Psychiatrist, Goodmayes Hospital, Ilford
*DR H O M BRYANT	Medical Officer of Health, West Bromwich County Borough
*MR R S KING	Department of Health and Social Security
*DR G M FLEMING (now deceased)	Department of Health and Social Security

Secretary:

MR P D WATSON	Department of Health and Social Security

Observers:

MR C J BERRY (appointed 26.10.72)	Association of Municipal Corporations
MR W H HOPKIN (resigned 26.10.72)	Association of Municipal Corporations
MR T A NELSON	County Councils Association

Environmental Health Sub-Committee:

MR A J COLLIER (Chairman)	
MR G C BATESON	DR J R PRESTON
MR E M BIRTWISLE	MR R W J TRIDGELL
DR E COLIN-RUSS	MR F DIXON WARD
DR R E A S HANSEN	MISS R D B PEASE
MR J E HANNIGAN	

**Co-opted Members:*

*DR A HUTCHISON	Director of the Environment, City and County of Kingston upon Hull
*DR W C D LOVETT	Welsh Office
*DR S LUDKIN	County Medical Officer, Durham County Council
*MR P V MUSTON	Department of Health and Social Security
*DR J M ROSS (now deceased)	Department of Health and Social Security

Joint Secretaries:

DR J T JONES	Department of Health and Social Security
MR R MYERS	Department of Health and Social Security

Observers:

MR C J BERRY (appointed 26.10.72)	Association of Municipal Corporations
MR W H HOPKIN (resigned 26.10.72)	Association of Municipal Corporations
MR T A NELSON	County Councils Association

Co-ordinating Committee:

MR A R W BAVIN (Chairman)	
DR F D BEDDARD (appointed 23.10.72)	MR A J COLLIER
DR R W ELLIOTT	MR J H GARDHAM
DR F HAMPSON	MR W L HOOPER
MR W O JOLIFFE	MR W E LANE
DR R M SHAW (resigned 23.10.72)	MR S H A SHAW
MR F DIXON WARD	MR J P DODDS
DR J T JONES	MR G J OTTON
MR R A OWEN (resigned 1.12.72)	DR E SIMPSON
MR G H WESTON	MR R HALL WILLIAMS (appointed 1.12.72)

Secretary:

MISS R D B PEASE	Department of Health and Social Security

Observers:

MR C J BERRY (appointed 26.10.72)	Association of Municipal Corporations
MR W H HOPKIN (resigned 26.10.72)	Association of Municipal Corporations
MR T A NELSON	County Councils Association

APPENDIX B (Chapter 3)

ENVIRONMENTAL HEALTH SERVICES AND CONTROL OF NOTIFIABLE DISEASE

1. Under existing legislation medical officers of health have certain statutory responsibilities and a general duty to inform themselves on all matters affecting or likely to affect the public health in their districts, and to advise the local authority. Public health inspectors have similar statutory duties. These responsibilities and duties call for a detailed knowledge of the area and a close watch on developments to ensure that prompt action is taken to deal with any circumstances likely to adversely affect the public health.

2. The arrangements under which the new local authorities will get medical advice will therefore need to take account of the degree of involvement in the affairs of the district which is necessary to give the adviser an adequate understanding of its problems.

3. This broad field of responsibility can be conveniently divided into:

(a) Environmental health, including the wholesomeness and adequacy of water supplies, the disposal of wastes and pollution generally.
(b) Food hygiene, food safety and food borne disease control.
(c) Port health.
(d) Control of notifiable disease and food poisoning.
(e) General planning of services.

Environmental health

4. Local authorities are statutorily responsible under the Public Health Act 1936 for ascertaining that there is a sufficient and wholesome supply of water in their districts, and may continue to be responsible. The medical adviser will be required to interpret the results of chemical and bacteriological examination of water samples in the light of his knowledge of the water source, the pattern of results in the past and the possibility that contamination of the source may occur. Water undertakings will also require medical advice on the public health aspects of water quality and in relation to the health of employees who are in contact with water in the supply system.

5. Air pollution is monitored by most local authorities and this information is used in the study of the effects of air pollution on morbidity and mortality from respiratory diseases. If new developments in the area are likely to contribute significantly to existing air pollution levels a medical assessment of the possible adverse effects on the population may influence the location of the industry in relation to residential areas.

6. The disposal of sewage and domestic refuse is primarily an engineering problem but there are important public health implications in the choice of suitable methods and sites for disposal of wastes, particularly those containing toxic chemicals. The medical adviser must be aware of developments which could result in the contamination of streams or underground water sources endangering water supplies or giving rise to other environmental health hazards.

7. There are many other general public health problems including the effects of housing on health, noise, and the control of nuisance and other circumstances which may be prejudicial to health, on which a local authority may need medical advice.

Food hygiene, food safety and food borne disease control

8. Local authorities have responsibilities under the Food and Drugs Act 1955 and regulations made under that Act which relate to the fitness of food sold for human consumption, the hygiene conditions under which food is stored, prepared and offered for sale and the compositional quality.

9. Medical advice may be required for the interpretation of the results of chemical and bacteriological examination of samples and to assess the safety of food including milk which has been subjected to contamination or where potentially harmful substances have been shown to be present.

10. In the investigation and control of outbreaks of food borne disease, close co-operation between medical advisers and public health inspectors is essential. The medical adviser should receive the notifications of cases of food poisoning and he will also need to see results of food sampling and any other investigations that are undertaken. Decisions may have to be taken on the fitness of food for human consumption and on the exclusion of unfit persons from work—particularly those engaged in food handling. The reports which the medical officer of health now receives under the provisions of the Food and Drugs Act 1955 and regulations of certain illnesses or contact with infection in persons engaged in the handling of food and milk will be required by the medical adviser and he will also be responsible for the present duties of the medical officer of health to exclude food and milk handlers from their occupations where there is a risk from spread of disease in circumstances defined in the above mentioned regulations.

Port and airport health

11. The responsibilities of sea and air port health authorities relate to the health clearance of ships and aircraft, their passengers and crews under the Public Health (Ships) and Public Health (Aircraft) Regulations 1970 and also for seaport health authorities include the inspection of imported food under the Imported Food Regulations 1968; the wholesomeness of water supplies; and general public health matters in the area within their jurisdiction.

12. The health clearance of passengers and crews and measures to secure the surveillance of contacts of infection is the function of the Port Medical Officer. On behalf of the Secretary of State, medical examinations are also carried out under the provisions of the Immigration Act 1971.

Control of notifiable disease

13. Although the statutory responsibility will lie with the local authority district for the control of communicable disease this function must not be divorced from the prevention of communicable disease by immunisation and vaccination, which will be the responsibility of the area health authority within the reorganised NHS. Notifications of infectious disease which are at present

made to the medical officer of health will be required by the local authority who will be responsible for the institution of control of measures and the investigation of outbreaks. As now, much of the work involved in carrying out immunisation and vaccination will probably be performed by general practitioners.

General planning of services

14. Other questions with environmental health and general medical implications arise from time to time over a wide range of local government functions, for example in planning residential developments and urban motorways. Local government will continue to need the services of a medical practitioner to advise on these questions.

APPENDIX C (Chapter 3)

PREVENTION AND CONTROL OF NOTIFIABLE DISEASE AND FOOD POISONING

1. The Sub-Committee on Environmental Health discussed the responsibilities of local government and the reorganised National Health Service in relation to the prevention and control of:

(a) Notifiable disease which is food or water-borne and food poisoning.

(b) Other notifiable diseases.

(The term "notifiable" means "notifiable under the provisions of sections 47 and 48 of the Health Services and Public Health Act 1968 and the Public Health (Infectious Diseases) Regulations 1968".)

2. There are three distinct stages:

(a) Prevention.

(b) Notification, that is to say general arrangements by which the authorities become aware of the existence of an outbreak or individual cases.

(c) Follow-up action to control the spread of the disease (including the elimination of its source).

3. Responsibility for these functions is currently as follows:

(a) Responsibility for notifying the Medical Officer of Health rests on the clinician (the general practitioner or hospital doctor) diagnosing the disease or food poisoning. The MOH then takes any appropriate control action and sends a copy of the notification to the local health authority.

(b) Responsibility for prevention insofar as it is effected by routine vaccination and immunisation lies currently with the local health authority, though much of the work is in practice carried out by general practitioners. (There are of course no vaccinations against food poisoning, nor against some notifiable diseases.)

(c) Responsibility for prevention as far as this is affected by clean water, clean food, clean food premises and food handlers, sewage disposal etc. lies with county boroughs, boroughs and districts.

(d) Responsibility for control of an outbreak so far as control is effected by tracing of contacts and their vaccination (where appropriate); identification of carriers (sometimes involving medical examination, voluntary or enforced by magistrates at the request of the district MOH); suspension of food handlers from work; also rests with county boroughs, boroughs and districts.

4. After reorganisation the responsibility for prevention by routine vaccination and immunisation is assumed to be one for the area health authority. Responsibility for prevention as this is effected by clean water, clean food etc. is clearly one for local government. The Sub-Committee has considered whether

it is appropriate that responsibility for the control of outbreaks should lie with local government, as at present intended. (Whichever type of authority (NHS or local government) becomes responsible for the control of outbreaks, the medical adviser to the district council should be in overall control of all aspects of prevention and he will be the link between the area health authority and the district council.)

5. If the prime responsibility were placed on the National Health Service, the authority with this prime responsibility would also possess the necessary skills and the staff for the job (except that for PHI services they would have to call upon local government). Such a situation would be open to two objections:

(a) That sometimes action would have to be taken (e.g. suspension of a food handler from work, or the prevention of the sale of food) which the public might well find unacceptable from a non-elected body.

(b) The NHS would often be operating in a field (cleanliness of food and water) for which otherwise the responsibility lies with local government.

6. If on the other hand the responsibility were laid entirely on local government they would have the necessary authority to take follow-up action and would be under direct democratic control in doing so. Local government would sometimes need services of staff not normally under their control (e.g. nursing staff to take specimens from contacts) and have to vaccinate contacts and would have to secure such services from the area health authority.

7. The Sub-Committee recognised that whichever authority had prime responsibility it would be necessary for there to be full collaboration between the two. The Sub-Committee concluded that the deficiencies in a situation in which local government had prime responsibility (that they would need to call upon another authority for medical and nursing skills) were less serious than a deficiency which would arise in a situation in which the National Health Service had prime responsibility, that is to say in which they would need to rely on another authority to implement some of the actions which they thought to be necessary. In other words they agreed that one could not envisage a conclusion which required a local authority to implement direct action in control of the livelihoods etc. of individuals on the say-so of the National Health Service; and thus that they would not wish to argue against the present intention that, subject to Parliament approving the necessary legislation, the control of outbreaks should lie with local government.

APPENDIX D (Chapter 3)

EXTRACTS FROM PUBLIC HEALTH OFFICERS REGULATIONS 1959

Regulation 5

A medical officer of health of a county shall, in respect of the county for which he is appointed, in addition to any other duties which may be assigned to him by the county council, carry out the following duties:

(1) he shall inform himself as far as practicable respecting all matters affecting or likely to affect the public health in the county and be prepared to advise the county council on any such matter; and for this purpose he shall visit the several county districts in the county as occasion may require, giving to the medical officer of health of each county district prior notice of his visit, so far as this may be practicable;

(2) he shall perform all the duties imposed on a medical officer of health of a county by statute and by any orders, regulations or directions from time to time made or given by the Minister;

(3) he shall as soon as practicable after the 31st day of December in each year make an annual report to the county council for the year ending on that date on the sanitary circumstances, the sanitary administration and the vital statistics of the county, containing in addition to any other matters upon which he may consider it desirable to report, such information as may from time to time be required by the Minister, and furnish the Minister with as many copies of such report as the Minister may from time to time require;

(4) he shall furnish the Minister with one copy of any special report which he may make to the county council.

Regulation 15

A medical officer of health shall, in respect of the district for which he is appointed:

(1) inform himself as far as practicable respecting all matters affecting or likely to affect the public health in the district and be prepared to advise the local authority on any such matters;

(2) perform all the duties imposed on a medical officer of health by statute and by any orders, regulations or directions from time to time made or given by the Minister, and by any byelaws or instructions of the local authority applicable to his office;

(3) forward to the Minister by post every week in time to ensure its delivery on Monday, or the morning of Tuesday at the latest, a return, in such form as the Minister may from time to time require, of the number of cases of infectious disease and of cases of food poisoning and suspected food poisoning notified to him during the week ended on the preceding Saturday night; and also (in the case of a county district) forward at the same time a duplicate of the return to the medical officer of health of the county in which the district is situated;

(4) as soon as practicable after the 31st day of December in each year furnish to the Minister a report for his district (or in the case of a union of districts for each district within the union) for the year ending on that date, relating to overcrowding within the meaning of the Housing Act 1957, and showing:
   (a) the number of dwellings overcrowded at the end of the year together with the number of families and the number of persons dwelling therein;
   (b) the number of new cases of overcrowding reported;
   (c) the number of cases of overcrowding relieved and the number of persons concerned;
   (d) particulars of any case in which dwelling-houses in respect of which the local authority have taken steps for the abatement of overcrowding have again become overcrowded;
   (e) any other particulars with respect to conditions in relation to overcrowding upon which he may consider it desirable to report or which the Minister may from time to time require.

(5) as soon as practicable after the 31st day of December in each year make an annual report to the local authority for the year ending on that date on the sanitary circumstances, the sanitary administration, and the vital statistics of the district, containing in addition to any other matters upon which he may consider it desirable to report, such information as may from time to time be required by the Minister, and furnish the Minister with as many copies of such report as the Minister may from time to time require;

(6) furnish the Minister and, in the case of a county district, the county council with one copy of any special report which he may make to the local authority;

(7) forthwith report to the Minister any case of plague, cholera, smallpox, yellow fever, louse-borne typhus or louse-borne relapsing fever or any serious outbreak of disease or food poisoning in the district which may be notified to him, or which may otherwise come or be brought to his knowledge, and, in the case of a county district, also notify the medical officer of health of the county.

APPENDIX E (Chapter 5)

NURSE INVOLVEMENT IN THOSE AREAS OF WORK SHARED WITH SOCIAL WORKERS IN COLLABORATION WITH GENERAL PRACTITIONERS

General

1. The needs of the individual in the family cannot always be divided into separate compartments and comprehensive care is therefore dependent upon both social and health services being available. Co-operation between the health services and personal social services is of prime importance to their effectiveness and recent local authority social services letters have drawn authorities' attention to the need for the preservation and extension, at all levels, of the close working relationships between both services.

2. The following paragraphs identify major client groups where there is close interlocking of nursing and social dependency, indicating the nurse involvement with each group.

Child health

Pre-Natal Period

3. The role of the health visitor is to participate in parent-craft teaching, when necessary helping parents develop the right approach to family life and teaching the art of child care. She will identify adverse factors to health within the home environment and ensure that relevant information is given to staff in the maternity service.

Post-Natal Period

4. The health visitor will visit the mother and baby as soon as the skills of the midwife are no longer required. Her role is to identify high risk families and ascertain families that require health support. The health visitor is trained so that she is able to recognise early deviation from the normal; and to be alert to the early recognition of the "Battered Baby Syndrome" and the prevention of the increase in violent deaths of babies. The health visitor participates in the domiciliary family-planning service, not only advising but actively helping to ensure that the recommended method of contraception is practised. She will be in contact with women in types of problem families likely to be in need of the domiciliary family-planning service.

5. The health visitor works with doctors in child health clinics and participates in developmental paediatrics, undertaking the appropriate screening and developmental tests. She is thus able to ensure that any deviation from the normal is recognised and that such cases are referred to the doctor for further assessment. In the course of her work the health visitor provides health education on the need for prophylaxis, vaccination, immunisation, etc. and she undertakes these procedures within the surgery or health centre.

Pre-school Period

6. The health visitor undertakes the health supervision of children in nurseries, foster homes, with child minders or nursery schools. In this aspect of child health care, the health visitor should work closely with the social services department. The health visitor helps families with children who have handicaps and emotional behaviour problems, for example to support families with children who have diabetes and other physical disabilities. In these cases the health visitor will liaise with social workers. Increasingly health visitors with doctors undertake a pre-school examination of all children after their fourth birthday.

School Age Including Further Education

7. Within the school health service the health visitor works as the health visitor/school nurse, deploying supporting nursing personnel and undertaking screening tests, immunisation programmes, hygiene inspections, health education; and gives special attention in the school situation to handicapped children and continues to assist in the support of these families.

Care of handicapped children

8. The health visitor in collaboration with the doctor undertakes regular developmental screening of young children, particularly those at special risk, in order to detect as early as possible the deviations from normal development.

9. Supporting services are needed for the child and for the family. Within this context, the family doctor and community nursing staff undertake the whole range of health supporting services and it is hoped will liaise closely with the social workers who will be brought in to undertake special social support to these families.

10. The needs of the handicapped child and of his family should be assessed by a multidisciplinary team which should cover health, social and (as the child grows older) educational aspects. Reassessment at regular intervals should be an important feature of the care provided, while less formal but more frequent assessment will be made by those in contact. The health visitor and the family doctor have an important role in these assessment services.

11. The principle of collaboration is set out in paragraph 40 of the White Paper "Better Services for the Mentally Handicapped" (Cmnd 4683) which states that "there should be close collaboration between the social services and those provided by other local authority departments (e.g. child health services and education), and with general practitioners, hospitals and other services for the disabled". This applies with equal force to the physically handicapped.

Elderly and physically handicapped people

12. General practitioners, increasingly, are maintaining an age/sex register. Thus, district nurses and health visitors attached to practices are able to visit the elderly on the list in order to discover the elderly at risk. They are able to assist in screening procedures, including the taking of blood for haemoglobin estimation, blood pressure estimation or any other test. Nurses in the community

are able to recognise pre-disposing factors of hypothermia and to recognise early signs of this condition. They are able to identify any deterioration, physical, mental or social, and report to the appropriate service. They are able to help the elderly and their families understand the normal physiology of old age, concepts of the ageing process and relevant principles of personal hygiene.

13. In addition, they ensure that equipment is provided to help old people and the physically handicapped maintain their independence and that adequate support is provided to enable them to remain in their own homes for as long as possible. When the elderly or handicapped require nursing care and/or nursing equipment at home, then nursing knowledge is also required, and this must be the responsibility of the health authority.

14. The social services department advised by the community nurses will provide supporting social services to the elderly and physically handicapped requiring such help. The addition of such support to that of the health services will enable many of the elderly and physically handicapped to continue to live at home.

15. In the important field of caring for the elderly and physically handicapped at home, a multi-disciplinary approach between the general practitioner and the community nursing service on the one hand, and the personnel of the social services department on the other, is essential.

Nursing in residential accommodation

16. Residential care is provided for many elderly and handicapped people who can no longer live in their own homes but who may need nursing care. At the present nurses employed by the local health authority are called in to give support by social services departments. It would therefore seem desirable that nurses are available to assess the nursing needs of residents and the content of nursing care to be given. The nursing content would include the provision of nursing care, the treatment of incontinence, the provision of the necessary equipment or advising on such equipment, the care of the diabetic including the giving of insulin injections, the checking and administration of drugs, and undertaking or advising on rehabilitation and methods of helping the patient towards self care. The responsibilities of the home nurse can thus be related to all persons requiring nursing care in residential homes.

Care of the bereaved

17. Whoever happens to be the right person at the time (whether health visitors, district nurses or social workers), is the one who should be responsible for offering initial comfort, sympathy and support for the bereaved. Further support should be arranged by the nurses in the community.

Working life

18. Nurses in the community assist general practitioners in health screening programmes. They undertake assessment visits for general practitioners as appropriate, and follow up those patients seen at the doctor's surgery who require health advice. Such advice includes nursing advice related to diseases and dis-

abilities that are associated with middle life. They see patients at the request of the family doctor who need counsel and support over and above advice given by the doctor. In the course of their work they advise patients as necessary of dangers of smoking, early detection of cancer, obesity and cardiac failure. They provide nursing support to patients discharged from hospital whether they require active nursing skills or health support. Both district nurses and health visitors are aware of any deviation or deterioration in these varying conditions and will report accordingly.

APPENDIX F (Chapter 6)

THE SCHOOL HEALTH SERVICE AT PRESENT: SCOPE AND ORGANISATION

CONTENTS

TABLES

I. ORIGINS OF THE SCHOOL HEALTH SERVICE

1. The school health service had its origins in the school medical service set up following legislation in 1906 and 1907 which authorised the provision of school meals for necessitous children and imposed on local education authorities (LEAs) the duty of medical inspection of school children. A main aim of the service was to ensure that school children were not denied, through unrecognised or untreated ill health, the opportunity to make the most of what school could offer them. While it was intended that the role of the service should be mainly preventive, routine periodic medical inspections revealed so many children needing treatment for defects which were hampering their progress in school that LEAs were to arrange for such treatment through voluntary associations or local hospitals or to make use of their power under the 1907 legislation to organise their own treatment service. By the 1940s the system of supervision and treatment under the school medical service, together with improved social conditions and a general improvement in nutritional standards, had led to a striking improvement in the health and physical condition of school children. At the same time the dental health of children had been improved by the dental inspections and treatment provided.

2. Under the Education Act 1944, section 48 (as amended by the Education Act 1953, section 4) LEAs have a duty to make arrangements for the compulsory medical and dental inspection of pupils and a duty to ensure that pupils receive medical and dental treatment either through LEA provision or otherwise. They also have powers to provide similar services for students under the age of 19 in maintained colleges of further education. The main statutory provisions are summarised in Appendix G.

3. The National Health Service Act 1946, under which, since 1948, free medical and dental treatment has been available for the school child, as well as for the child under five, created a new situation which has had a considerable influence on the subsequent development of the school health service. The need for the provision by LEAs of separate treatment facilities both medical and dental, has declined, though the demand for dentistry still exceeds what can be provided from present resources. Increasing use has been made of the specialist facilities of the National Health Service for diagnosis and assessment of children with handicaps which affect their educational progress.

II. SCOPE, ORGANISATION AND STRUCTURE OF THE SCHOOL HEALTH SERVICE

Scope

4. The aim of the partnership between the school health service, LEAs and schools is to secure the provision of a healthy school environment, to promote an understanding of the development of school children through surveys and studies, and to ensure that individual children whose health problems may affect their education are identified and helped. The school health service gives special emphasis in its work to preventive medicine. This includes health education, the detection of and arrangements for treatment of ill health, the preservation of dental health, and the detection of defects, leading to the assessment of, and advice on, physical and mental handicaps which might affect the education of individual children.

5. The doctors and nurses in the school health service are experienced in child health and child development, understand the education system, know what particular schools can offer and are known and trusted by staff and children. They advise on and help in the planning and giving of health education programmes. They can advise in any emergency of a medical nature, from an epidemic illness to a pupil suspected of taking drugs. The advice they offer on the health of teachers can ensure that decisions are taken for the benefit not only of the individual but of the school community.

6. In the field of special education, the school health service helps LEAs to forecast and provide for needs. Medical officers of the service take part in the assessment of handicapped children and can where necessary use their knowledge of the schools to help interpret the advice of specialists in terms of educational requirements. For children in special schools they contribute to a continuing assessment of their progress and needs.

Organisation

7. Since the Acts of 1944 and 1946, the same local authorities have administered the school health service and the local health services (except, since the Local Government Act 1963 took effect, in London). In practice, the Principal School Medical Officer (PSMO) administering the school health service and the Medical Officer of Health (MOH) of the local health authority are, with two exceptions only, the same person and about 90 per cent of medical officers employed by local authorities work in both services. Similarly, in many areas the school dental service and the priority (maternity and child health) dental service are administered by the same dental officer. In most areas also school nursing duties are performed by health visitors and the management of the school nursing service is the responsibility of the local authority's Director of Nursing Services.

8. There are of course variations among authorities in their committee systems, ways of organising school health service work, and channels of communication at working level between the PSMO and his team and the Chief Education Officer (CEO) and his staff. In some areas the staff responsible for planning and organisation will work in the same building, or, if the system is decentralised, at least from the same local offices; in others they may be in separate premises. Usually there is close personal communication at all levels, both in determining policy towards the education of handicapped children and other aspects of education to which medical considerations are relevant, and in considering individual problems (including, for example, those connected with the employment of teachers). In practice, the administrative responsibility for the school health service is usually devolved on a senior member of the medical staff who devotes all or the major part of his time to school health service work. He is usually responsible also for the medical aspects of the provision of special education. In the education department, there is usually a similar devolution to the deputy education officer or an assistant education officer, of administrative responsibility for services for handicapped children. There is normally very close liaison between these officers and their opposite numbers on the medical side.

Medical Examinations

9. The purpose of the school medical examination is not primarily to examine a child for defects but to identify those children with defects which may adversely affect their education, so that these adverse effects may be countered by early and if necessary continued treatment and/or by the provision of special educational facilities. The trend for some years has been away from routine medical examinations of all children (apart from examinations on entering school) and towards a more selective system which enables school doctors to give more time to those children who are likely to have developmental and educational problems, and to discussion with their parents and teachers. Allied to the move towards selective medical examinations has been a trend towards a greater emphasis on the screening of those aspects of school children's health likely to have educational implications.

10. 1,786,329 children in England and Wales were medically examined at periodic (routine) inspections in 1970 (22% of the total number of children on

the school roll) and there were 1,179,315 special inspections or re-inspections of children whose health gave cause for concern. Figures for preceding years are given in Table III and show a gradual decline in inspections. The general physical condition of the pupils inspected at routine medical inspections has been found to be good: only about 0.3 % were found to be in an unsatisfactory state of health in 1970, but about 15 % of pupils given routine inspection were found to have a defect, often comparatively minor, requiring treatment of one sort or another. Studies made by individual LEAs suggest that about half these defects were previously undetected. In 1970 164,800 children were known to have been treated, by LEAs or otherwise, for diseases of the skin, 434,900 for errors of refraction and/or a squint, 70,600 for various orthopaedic defects and 286,900 for various minor ailments. 2,400 children were supplied with hearing aids during the year, 5,600 were given convalescent treatment, 88,200 attended speech therapy clinics and 69,300 attended child guidance clinics. Just over 237,800 children were found to be verminous.

School clinics

11. Over the years there has been an increase in the number of audiology, chiropody, immunisation and speech therapy clinics. There are fewer heart and rheumatism clinics but more for asthmatic children and for such problems as obesity and enuresis.

12. In 1970 authorities provided 2,786 school health service clinics excluding those held in child guidance clinics. Little information is available about the location of clinics; some take place in premises used only for school health service work, some in premises also used for other health authority work and some at health centres. Some clinic premises are in schools. In 1970 special clinics were held for the examination and/or treatment of the ailments shown in Table A below:

TABLE A—School health service clinics

Examination and/or treatment	Number of premises available as at 31 December 1970
(i) Minor ailment	1580
(ii) Asthma	63
(iii) Audiology	395
(iv) Audiometry	792
(v) Chiropody	305
(vi) Ear, nose and throat	214
(vii) Enuretic	236
(viii) Ophthalmic	955
(ix) Orthoptic	121
(x) Orthopaedic	281
(xi) Paediatric	52
(xii) Physiotherapy and remedial exercises	427
(xiii) Speech therapy	1605
(xiv) School medical officer's special examination	1402
(xv) Others	589

Premises are usually used for more than one type of clinic. The total number of clinic premises is probably between 1,600 and 2,000. Because of the lack of detailed information on the extent to which clinics are used, together with the fact that a large amount of work is done outside school clinics, this description does not provide a full indication of the work done under the various headings. Whilst GPs could possibly take over more treatment of minor ailments, more specialised clinics may need to be a continuing feature of the service.

The work of school medical officers

13. The main items of medical work are as follows:

(i) Assessment and guidance about the special education of handicapped children from the age of 2.

(ii) Medical supervision of children in nursery schools.

(iii) Examination of school entrants.

(iv) Examination of other new admissions to ordinary schools, including transfers from other LEAs.

(v) Routine follow-up examinations or follow-up of certain entrants during the first and/or subsequent years.

(vi) Special examinations, for example of pupils referred by teachers, school nurses, parents.

(vii) Discussion with the head teachers and staff of every ordinary school.

(viii) Examination of children as part of the process of ascertainment for special education.

(ix) Review of handicapped children in special and ordinary schools and discussions with head teachers and teachers.

(x) Work connected with senior secondary school pupils, such as the medical counselling of senior pupils, the medical examination of school leavers and reports on suitability for full-time and part-time employment, including reports upon request to the Employment Medical Adviser. Advice to teachers and non-medical counsellors.

(xi) Lectures etc including health education sessions in schools.

(xii) Liaison with other members of the medical profession and contact with social work agencies.

(xiii) Investigation and control of outbreaks of infection in schools.

(xiv) Advice on hygiene and safety precautions in consultation with public health inspectors, and medical advice, where required, in connection with the provision of school meals.

(xv) Interviews and examinations of students in further education establishments.

(xvi) Special surveys.

(xvii) Advice about the health and physical capacity for teaching of teachers and of students.

The pattern of organisation of medical work varies. In some areas individual medical officers may carry out all or the majority of these items of work; in others there may be some degree of specialisation, particularly in the examination of handicapped pupils. Some medical officers, usually the more senior, will be involved with administration, planning, and committee work and with special education. They will also be available, if necessary, to advise medical officers working mainly in the field.

Time required of school medical officers

14. The amount of medical time required depends to some extent on LEA policy. In some areas, for instance, all pupils are examined on entry to primary and secondary school, and before leaving school; others use a system of selective examinations, but the medical examination itself may be more time-consuming under a selective system. Other relevant policy matters are the frequency of follow-up examinations, the amount of time spent in discussion with individual pupils and parents, with school and child guidance staff, and with other doctors and social work agencies. The average ratio of full-time equivalent (FTE) doctors to pupils at the end of 1970 was one doctor per 7,865 pupils. If all known vacancies were filled this ratio would be about 1 : 7,000, but this does not necessarily indicate the total number of staff required for the school health service. The ratio of pupils to doctors has increased over the years. Ratios for previous years, and the number of nursery, primary, secondary and special school pupils are set out in Table III.

Numbers of medical staff employed

15. Table I gives a summary for England and Wales of the medical and other staff employed in the school health service in 1970. Table II* gives comparable information for medical staff at 5 year intervals since 1950. Over the past 20 years there has been a decrease both in actual numbers and in the FTE of those shown as employed solely by the school health service and an increase in those employed jointly with the local health authority. In 1970 3,280 medical officers (equivalent to 1,058 full-time officers) were employed by the school health service. The 116 employed full-time are probably senior school health service medical administrative staff. 1,888 (including 1,056 working full-time) combine school and local health authority work. Their total time, and that of those employed solely in the school health service, was equivalent to 882 whole-time medical officers. (There are about 250 full-time equivalent medical officers employed by the local authorities for maternity and child health work.) Information about general practitioners and other doctors working part-time for the school health service is given in Table B below. (Separate figures for the two groups were not collected before 1969.)

* In 1969 LEAs were asked for the first time to distinguish in their returns between those employed full-time and part-time and to divide those previously returned under the heading "general practitioners working part-time in the school health service" between those working in the school health service and for the rest of their time in general practice and those doing other medical work. The latter group is largely made up of married women working part-time for the school health service and also having some other work in, for example, family planning clinics or in hospitals.

TABLE B—GPs and others working part-time in the school health service

		Number		FTE
1965		803		127.42
1966		921		141.73
1967		948		151.93
1968		1117		174.8
1969	GP 726	1231	92.0	183.0
	Others 505		91.0	
1970	GP 718	1203	88.0	175.7
	Others 485		87.7	

On average those GPs working in the school health service give 12% of their time to it.

Specialist and consultant staff

16. There has been little change between 1965 and 1970 in the number of ophthalmic specialists and "other" consultants and specialists reported as "employed in the school health service for specialist examination and treatment only". On average each ophthalmic consultant provides the equivalent of about 2 sessions a week and "other" consultants just under one session a week. Authorities are not required to indicate the specialty of the "other" consultants; some do however and list mainly paediatricians, psychiatrists, ear, nose and throat specialists, orthopaedic specialists, and anaesthetists. The sessions may be given at local authority clinics or at special schools. LEAs may also arrange with Regional Hospital Boards (RHBs) for consultants to see school pupils in hospital. In one area, for example, clinics for severely handicapped children from a special school are held at hospital.

Qualifications of school medical staff

17. No special qualifications or training are required of doctors who work in the school health service unless they are called upon to examine mentally handicapped pupils. A high proportion of them have a DPH. Some will have held posts in hospital paediatric departments but relatively few (approximately 25%) have a DCH. Many have attended a 3–4 week course approved under the Medical Examinations (Subnormal Children) Regulations 1959, and are thus qualified to examine pupils who may be educationally or severely subnormal. Four such courses are organised each year in England. They have traditionally concentrated principally on providing instruction and practice in the carrying out of a test of intelligence, using the Stanford Binet Scale. A fundamental change is now being made in the content of the courses, so that they are more broadly based on developmental paediatrics and the neurological examination of children with a variety of disabilities which may cause physical or mental handicaps and difficulty in learning.

Recruitment of medical staff

18. Most of those who enter school and local health authority service work do so because it offers full-time or part-time work with children in a field in which

they are interested. Others are involved temporarily in the clinical work of the service as part of the training for a full-time career in the public health service. A great many of those who work in the school health service (and the local health services) are women who may vary the amount they work over the years according to fluctuations in family commitments. While in some areas, particularly those with good residential facilities nearby, recruitment of part-time staff is not difficult, in others there are considerable difficulties. Uncertainties about the future of the school and local authority medical services and the continuing lack of career prospects within the service for those interested in clinical paediatrics have made it increasingly difficult for LEAs to fill posts. In 1970 there were vacancies for 181 FTE medical officers, 149 for posts held jointly with the local health service. These figures may include both vacancies which LEAs have been unable to fill and those which, though on establishment, they have decided not to fill. No information is available about turnover, mobility or age structure.

Nursing staff

19. The functions of the school nursing service are to provide services for both the child and the school and to maintain a link between the child, the home, the school and general practice. Certain reports and circulars have had an important bearing on the function of the school nursing service.

(i) *School health service regulations*, 1945

These regulations required (subject to saving clauses for existing staff and for nurses employed solely in school clinics, in boarding special schools, or on specialist duties) that all school nurses should, in future, be qualified health visitors. This requirement was intended to facilitate the co-ordination of school and maternity and child welfare nursing services, and to secure continuity in the nursing supervision of pre-school and school children, in areas where there was separate school and maternity and child welfare services. (The current regulations also incorporate this requirement.)

(ii) *Circular* 12/65, *use of ancillary staff in the local authority nursing services*

This circular referred to a report to the sub-committee of the Standing Nursing Advisory Committee on the use of ancillary help in the local authority nursing services. The terms of reference were:

> "To consider to what extent the nursing team and the local authority service could be developed and how far its effectiveness could be increased by the employment of other professional and non-professional workers. The examination should include consideration of state registered nurses, state enrolled nurses, cadets (by secondment or otherwise) and voluntary workers."

Although the sub-committee realised that advice on the school health service was, strictly speaking, outside their terms of reference they decided that, as nursing staff is employed in the school health service as well as in the local health authority service and a large number of health visitors divide their time between the two, it would have been wrong not to have considered the use of ancillary staff in the school health service where such consideration followed naturally upon, or was closely parallel to, the committee's discussions of the local health

authority services, particularly as the availability of health visitors for work under the local health authority is affected by the numbers needed in the school health service.

The report described the nature of duties that were undertaken in the school nursing service and also considered how these duties could be delegated without affecting the quality of the service to the child.

The report stated "the health visitor should lead the nursing team in the school health service as in the local health authority service and should similarly be supported by state registered nurses, state enrolled nurses and lay assistants. She should work closely with parents, class teachers as well as head teachers, other officers of the education authority and with school doctors and general practitioners. Much of the home visiting in connection with schoolchildren will need to be done by her. We think she should be present at the medical examination of the children on first entry to school but it will be more economical of her time to consult with the school doctor and head teacher before or after other routine medical examinations. We do not think that she need normally attend any of the clinics provided under the school health service. She should play an active part in health education, particularly of the young."

(iii) *Circular* 13/69 "*Attachment of local health authority nursing staff to general practices*"

This circular drew the attention of local health authorities to a report of a study undertaken by the Department's Social Science Research Unit on the staff implications of general practice attachments of health visitors and home nurses.

The Secretary of State commended the conclusions contained in the report for careful consideration by authorities. The Secretary of State hoped that local health authorities would give serious consideration to the desirability of introducing or extending schemes of attachment or association with general practitioners.

(iv) *The report of the working party on management structure in the local authority nursing services, dated October* 1969.

This report stated "the work of the school nurse/health visitor and her team is concerned primarily with medical inspection and immunisation, home visiting of school children with mental or physical defects, and with health education and counselling of parents and teachers. While in practice the school nursing service operates in most areas within the local authority nursing structure, the separate administration of the two services in some areas has sometimes resulted in inefficient deployment of nursing staff.

The need to reconcile the demands of the school service on the health visitor/school nurse with a need to provide continuing cover for her work in the community which itself is imposing growing demands on her time, inevitably presents additional problems of management within the community nursing services. The shortage of health visitors generally, and of school nurses with the health visitor's certificate, in relation to the rising school population are matters of concern for management.

The effects of these additional problems are reflected at all management levels. Besides her school responsibilities the health visitor/nurse at field work level organises the work of her team. The first line manager is responsible for the school nursing service within the health visiting service of her unit; she is required to

act as consultant in all aspects of her work within the school nursing service, including health education, screening techniques and special problems of immigrant children. Important problems for middle management include deployment of staff involving programming the work of increasing numbers of part-time married staff, and provision of in-service training. The top nurse manager needs to involve herself directly in all policy matters relating to the school nursing service. She is in frequent consultation with the Director of Education and the Principal School Medical Officer and their staffs, with school welfare officers and social workers and with organisations within the field of education including parent/teachers associations and juvenile employment agencies."

Functions of nursing staff

20. It is now generally accepted that the role of the health visitor/school nurse in schools is primarily that of health educator and general adviser on health matters and to act as leader of the nursing team ensuring effective liaison between the school and other agencies concerned with the health of the schoolchild.

(a) *Responsibilities of the health visitor and health visitor/school nurse*

(i) Health education and advice to all families or individuals she visits in the home, the doctor's surgery, the school, clinic or health centre.

(ii) A regard for the medical, psychological and social needs of the whole family. The health visitor must also be aware of the help given by other workers.

(iii) A readiness to take account of psychological factors in every case with which she deals. At all times the health visitor should be aware of her role in the promotion of mental health and the prevention of mental illness.

(iv) Comprehensive counselling services to families in need, and seeking appropriate help from other agencies.

(b) *Functions of the health visitor/school nurse within the school health service*

(i) Provides the principal health link between the home, the school, the family doctor and other agencies, particularly on matters relating to the health of the schoolchild.

(ii) Discusses relevant home problems with the head teacher and in turn relates school problems to the home background.

(iii) Works within the school as school nurse and health educator.

(iv) Is available to discuss medical and social problems with the school doctors.

(v) Carries out health surveys as and when required.

(vi) In liaison with the medical officer of health deals with any outbreak of infection and relates the necessary health education to the families concerned.

(vii) Gives the fullest support to the homes of children with emotional or behaviour problems and children with other handicaps.

(viii) Within the school, makes arrangements for (and attends as necessary), school medical inspections, screening tests for sight and hearing, hygiene inspections, special clinic sessions and immunisation programmes, and ensures that proper records are kept.

(ix) Has special responsibilities for all handicapped children.

Numbers of nurses employed

21. School nursing numbers and work have increased by about a third over the last twenty years (Table IV). Table I shows that there were in 1970 nearly 9,500 nurses of whom over 6,800 were qualified as health visitors, and 642 unqualified assistants. Of the 198 employed solely in clinics, 21 were qualified as health visitors. A FTE of 88.5 school nurses worked solely in clinics, and the FTE of 3,224 (1,896 with health visitor qualifications and 1,328 without) worked in clinics and elsewhere.

Other professions

22. The school dental service is described in paras 39–50 below. Table I(a) shows the numbers of staff in professions supplementary to medicine employed in the school health service in 1970. These included by LEAs in the "other" category include remedial gymnasts, occupational therapists, and various types of technicians.

23. Speech therapy services have been reviewed by a committee under the chairmanship of Professor Randolph Quirk. The committee considered inter alia the need for and the role of speech therapy in the field of education and of medicine and the possible organisational structure of speech therapy services in future. It has now reported.

II. HANDICAPPED CHILDREN AND CHILD GUIDANCE

24. The education service is responsible for educating children with a wide range of handicaps, from those who are apparently normal but fail to make progress to those who have severe physical or mental handicapping conditions.

25. It may be apparent from a very early stage that a child is handicapped. LEAs have a duty under section 34 of the Education Act, 1944 to provide special education from the age of 2 for any handicapped children whom they consider to require it. Close liaison between the medical and health visitor services for young children and the education service is essential. The nature of the liaison arrangements varies between authorities and there is no precise borderline between the responsibilities towards young handicapped children of medical officers working within the health authority and the school health services. The health and education services receive information from hospitals and general practitioners about handicapped children. LEAs must receive adequate medical information as early as possible since some form of "special education" to assist in the child's development may be required from the age of 2, either at home (e.g. for a deaf child by means of a peripatetic teacher) or through special arrangements in nursery and special schools. Even if special education is not immediately necessary, LEAs need to know about handicapped children well in advance of compulsory school age so that they can prepare to provide the facilities needed.

26. Some handicaps may not become apparent until children are at school. Mental retardation may not become evident until the child reaches infant school and maladjustment may not be observed until later in the school career. There are however indications from recent studies that the symptoms of potential maladjustment could be detected earlier.

27. Comprehensive assessment of a handicapped child means examination of the medical, social, psychological and educational aspects by a basic team consisting of doctor, social worker and educationist, who may be a psychologist or a teacher, supplemented by other specialists as needed. There is no uniform pattern of organisation of assessment services.

28. For very young children, or for the minority whose diagnosis requires advanced medical techniques or complex facilities, the medical aspects of assessment may have to take place in hospital. The emotional associations of hospital, and the inconvenience sometimes involved in outpatient attendance, may however make assessment more difficult by causing atypical behaviour in the child or his parents. For less severe problems, many LEAs have a senior medical officer or officers with a great deal of expertise in child development, who can conduct their own assessment clinic and organise preliminary screening, working closely with educational psychologists, and referring children as necessary to hospital for further examination and diagnosis.

29. The purpose of assessment is to decide upon a suitable form of treatment, including special educational treatment. Development patterns observed in the school may have relevance for the medical aspects of assessment, and similarly a clear understanding of the medical picture will be required by the school. The process of interpretation by the educationists and doctors of interdependent educational and medical aspects of a child's developmental problems is greatly facilitated by having school medical officers who are skilled in child development and knowledgeable about both special and ordinary schools.

30. The third facet of assessment, that of social needs, also requires co-ordination of information about medical and educational decisions and social problems which may affect educational placement. The school nurse/health visitor (in co-operation with local authority social workers) can provide an essential link between the schools, the parents of handicapped children and the social service agencies concerned.

31. Returns from LEAs showed that at January 1971, 116,000 children had been assessed as needing special educational treatment at special schools or in boarding homes (about 21,000 of these children were newly assessed during 1970). In addition there would have been a substantial number of handicapped children who were receiving their education in ordinary schools and 3,500 in hospital schools (see Table V), and who were not included in these returns. In January 1971 the returns showed that 88,000 were in special schools of whom 23,000 were boarders. There were also 14,000 handicapped children receiving special education in special classes and units (excluding those for the educationally sub-normal (ESN)), independent schools, boarding homes and in hospitals, other groups or at home under arrangements made under Section 56 of the Education Act 1944. About 4,900 were in special classes or units, 4,700 in independent schools and 2,000 at home. Another 14,000 children were awaiting admission to special schools, 700 were under 5; the great majority of these were receiving education meanwhile in ordinary schools. The largest group of children in special schools are those classified as educationally sub-normal. (These figures do not include severely mentally handicapped children for whose education the education service

assumed responsibility on 1 April 1971 and who are now in special schools for the educationally sub-normal, hospitals schools and units and independent schools.)

32. Parents have a right of appeal against a decision that a child requires special education. Decisions are in practice often reached informally and as a result of discussion and consultation with parents without the formal "ascertainment" procedures being invoked. However, parents do sometimes dispute decisions. In deciding whether special education is necessary the authority takes into account information from their medical staff (which may include reports from consultants) educational psychologists, nursing staff, social workers and parents, in addition to information from teaching staff.

33. The school health service provides skilled medical, dental and nursing assistance for special schools; in addition physiotherapists, speech therapists, and occupational therapists may be employed in special schools. In boarding schools medical cover of two kinds is required; first, general medical care, which is usually provided by a general practitioner who has the children on his list, secondly, supervision of progress, which is carried out by a school medical officer of the LEA experienced in the development of handicapped children. In addition there may be visits by a consultant, e.g. by a consultant psychiatrist in a case of special schools for maladjusted children, or by a paediatrician or orthopaedic specialist in the case of schools for physically handicapped children. In day special schools children are under the supervision of the school medical officer, and also on the lists of their family practitioners. Special schools, boarding and day, employ nursing and child care staff and lay ancillary helpers, and in some cases social workers.

Child guidance

34. Children with serious emotional or behaviour problems are referred to child guidance clinics for assessment by a multi-disciplinary team, usually comprising a child psychiatrist, an educational psychologist, a psychiatric social worker, and, in some areas, a child psychotherapist. Sometimes a small teaching unit is attached. The administrative arrangements under which the clinics are run vary from one LEA to another, and while the educational psychologist is almost always a member of the school psychological service, other members of the team may not be employed by the LEA. The child psychiatrist, for example, is usually employed by the Regional Hospital Board.

IV. HEALTH EDUCATION

35. The school years offer unique opportunities for health education, since this is when values and ideas are formed and when information can be presented sensitively and naturally as interests develop. The term "health education" covers a very wide range from simple hygiene to complex issues of personal relationships and behaviour, and the teacher's experience and intimate knowledge of his pupils are essential in judging when, and by what means, to present the more sensitive aspects. However, doctors, dentists and nurses from the school health service have a very valuable contribution to make and have over the years

been brought increasingly into health education at school. They can advise on the planning of programmes of health education as well as guiding teachers on the medical aspects and participating themselves by giving talks and joining in discussions. Some local authority health departments employ full-time Health Education Officers who are assisting health education in schools by providing visual aids and other material, giving talks and advice on the choice of specialist lecturers, or providing in-service training for teachers engaged in health education.

V. STATUTORY REQUIREMENTS FOR EXAMINATIONS AND REPORTS BY SCHOOL MEDICAL OFFICERS

36. Medical Officers of LEAs are formally charged under section 54 of the Education Act 1944 with setting in train the procedure for ensuring that cleanliness is maintained, and that outbreaks of infestation by nits or lice are dealt with. There is also a requirement under section 59 that school pupils shall not do part-time work if it is likely to prejudice their health, and the school medical officer may be called on to advise about this. School medical officers also inform the Careers Advisory Service of school leavers who may be unsuited to certain types of employment. The Employment Medical Advisory Service Act requires school medical officers to provide medical records and other medical information about these young people to employment medical advisers if so requested. Under the Education (Milk) Act 1971 the school medical officer is required to decide which school children aged 7–12 should be provided with school milk on medical grounds.

VI. USE BY LEAs OF THEIR POWERS UNDER SECTION 48(3) AND (4)

37. In addition to arrangements which the LEA may make to provide treatment, these powers are also used by individual LEAs to cover the direct provision of appliances, facilities or services, for example, commercial hearing aids when they are required, electric bell apparatus for eneuretic children, and incontinence pads, extra milk for diabetic children, or gluten-free bread. The provision of convalescent holidays and payment of travelling expenses for visits to clinics, hospitals, etc. (and to provide escorts) have been regarded as being covered by these powers.

VII. THE SCHOOL DENTAL SERVICE

General

38. The school dental service came into being almost immediately after the establishment of the school medical service in 1907, to provide an inexpensive dental service for the majority of children whose parents could not afford to pay. In 1918 legislation placed a duty on LEAs to make dental arrangements for children attending public elementary schools. Further legislation permitted the treatment of expectant and nursing mothers. The duty to provide free dental inspection and treatment for all children in maintained schools, subsumed in section 48 of the Education Act 1944 was specifically provided for by Section 4 of the Education (Miscellaneous Provisions) Act 1953.

39. The object of the service from the outset was the conservation of children's teeth. From 1912 a series of school dental schemes have been published by the DES, or Board of Education as it was then, setting out desirable standards. The most recent of these was published in 1963.

40. At the establishment of the National Health Service in 1948 it was recognised that the demand for dentistry would be greater than the general dental service could meet. LEAs were advised to expand their services to give preference to priority groups. It was envisaged that joint use would be made of school dental service resources and that the Senior Dental Officer of the local authority service would be responsible for running the combined service.

41. The responsibility for the efficient conduct of an authority's health service belongs to the MOH/PSMO. The Principal School Dental Officer (PSDO) is responsible through him for the efficient conduct of the dental services. As an important step towards providing an advisory service for local authorities, a Joint Dental staff was formed in July 1963 whereby arrangements were made for the Chief Dental Officer of the Ministry of Health to be given additional responsibilities as Chief Dental Officer to the Department of Education and Science.

42. When the National Health Service started, there was a very great demand from the public for dentistry with the result that few children received treatment from the general dental service. Since then the general dental service has increased its coverage and the improved pattern of dental care of schoolchildren is a testimony not only to improved methods of treatment within the school dental service but also to increased provision of treatment for children by general dental service practitioners. In 1970 6,400,000 full courses of treatment and 350,000 emergency treatments were given to children under the age of 16 by general dental practitioners. The school dental service inspected in 1970 over 4,500,000 children (about 56% of the school population). About half were found to require treatment and just over 1,300,000 were treated by the school dental service. 455,000 school pupils were reinspected of whom 271,000 were found to require treatment. Pupils being given treatment made 3,563,000 attendances.

Duties of a dental officer

43. (i) Dental inspection of children, usually in school. This takes 6% of Dental Officer sessional time per annum. On average 2,676 children were inspected per dental officer during 1970.

(ii) A further 5% of time is spent on the maternity and child welfare services.

(iii) Almost 88% of time is spent on treating school children. Most of this work is conserving teeth. 5.5 fillings are completed per treatment session. 10% of visiting children require general anaesthetics, 4% for emergency treatment. Dental officers administer 28% of general anaesthetics given in the local authority service.

(iv) A small percentage of time is spent on preventive measures.

(v) Increasing efforts are being made to provide a better service for handicapped children.

(vi) Supervision of dental auxiliaries. The dental officer initiates programmes on dental health education and the dental auxiliary carries them out under his supervision.

44. Although the school dental officer may have less contact with teaching staffs than the school doctor, he may visit and work in schools as well as see children at clinics. School routine is less disrupted by a visit to an LEA dental clinic near the school premises than to a dentist less favourably situated. There are almost 250 mobile clinics in use in the service to bring treatment to remote schools.

45. The distribution of dentists over the country as a whole is uneven, with a concentration in the south. General dental practitioners under contract with executive councils are independent contractors and are under no obligation to accept children for treatment: they will not usually accept those whose treatment is not an economic proposition under an "item of service" basis of payment. For instance the dental care of mentally and physically handicapped children always requires more time than can be adequately remunerated under the present system of general dental service payments. On the other hand, the staffing of the school service, although subject to some geographic variations, is on the whole more even and, as there are no financial disincentives, treatment is equally available to handicapped and normal children. Unfortunately the school dental service generally is severely understaffed.

46. The service carries out surveys of dental caries in children from which valuable statistics are derived.

Staff

47. After an initial loss of staff to the General Dental Services under the NHS in 1950 the school dental service has continued to gain strength. In 1970 there were 1,228 dental officers employed on a salaried basis and 714 part-time. In terms of full-time equivalents the total staff consisted of 1,461 FTE dental officers of which the FTE of 104 dental officers worked in the Maternity and Child Welfare Service leaving a FTE of 1,357 dental officers within the school dental service, representing one full time dental officer per 6,132 school children. The increase since 1950 is shown in Table VI. About 10% of active members of the dental profession are engaged within the local authority service. Nevertheless the service is still seriously understaffed.

48. Many of the very varied individuals working in the school dental service may have been attracted to working in a priority service with preventive aims. Those working on a sessional basis include general dental service practitioners who value their school dental service sessions as a welcome change from the "item of service" pattern of work. Some are married women who find general dental service practice incompatible with family duties. The dental officers are assisted by specialists and there are about 100 orthodontists who carry out work (usually sessional) for the LEAs. Use is also made of hospital consultants, either at clinics or within hospitals, when complex treatment is required.

49. The school dental service employs the FTE of 182 dental auxiliaries. Their training and examinations and the scope of their work is governed by the Ancillary Dental Workers Regulations 1968: they do simple fillings and may extract deciduous teeth. All are young women and wastage on marriage has hindered expansion of this part of the service: nevertheless their contribution is valuable. There are also the FTE of 17 dental hygienists and 1,748 dental surgery assistants in the service.

VIII. SCHOOL STRUCTURE

50. The size of schools is of relevance to the organisation of the school health service. There has in recent years been a tendency for secondary schools to increase in size. The sizes of primary and secondary schools in January 1971 are shown below:

Size of schools

	Schools with the following number of full-time pupils on the registers										Total
Size of schools	Up to 50 pupils	51 to 100	101 to 200	201 to 300	301 to 400	401 to 600	601 to 800	801 to 1,000	1,001 to 1,500	1,500 and over pupils	
Primary schools	2,456	3,003	5,302	6,498	3,608	2,036	139	12	—	—	23,054
Secondary schools	—	18	161	467	783	1,747	1,130	506	393	90	5,295

TABLE I—Staff of the school health service as at 31 December 1969

	Medical officers						Nurses and health visitors						Speech therapists							
							With health visitors' certificate		Without health visitors' certificate		Nurses' assistants									
	Solely school health service	Part-time school health service/rest of time local health service	Part-time school health service/rest of time as general practitioner	Part-time school health service/rest of time on other medical work	Ophthalmic specialists	Other consultants and specialists	Employed solely in clinics	Employed in clinics and elsewhere	Employed solely in clinics	Employed in clinics and elsewhere	Employed solely in clinics	Employed in clinics and elsewhere	Senior speech therapists	Speech therapists	Assistant speech therapists	Audiometricians	Chiropodists	Orthoptists	Physiotherapists	Others (excluding clerical staff)
Number:																				
England																				
Full-time	123	939	—	21	3	—	26	3399	121	955	49	222	67	253	—	82	47	9	120	103
Part-time	60	696	705	452	249	196	—	2755	87	1292	24	132	17	314	2	62	161	51	172	71
Wales																				
Full-time	1	120	—	18	—	—	—	426	3	127	—	13	4	15	1	1	—	—	1	1
Part-time	2	32	21	14	6	5	—	73	4	50	—	11	3	10	—	5	—	3	2	—
Total																				
Full-time	124	1059	—	39	3	—	26	3825	124	1082	49	235	71	268	1	83	47	9	121	104
Part-time	62	728	726	466	255	201	—	2828	91	1342	24	143	20	324	2	67	161	54	174	71
Whole-time equivalent:																				
England	137.2	599.5	89.5	81.9	55.2	18.0	13.0	1875.0	113.4	1159.3	37.9	181.5	73.1	372.2	0.9	95.7	25.9	24.8	169.2	112.5
Wales	1.2	60.0	2.5	9.1	0.5	0.3	—	124.0	3.4	46.5	—	12.0	5.3	18.6	1.0	3.1	—	1.1	1.5	0.7
Total	138.4	659.5	92.0	91.0	55.8	18.1	13.0	1999.0	116.8	1205.8	37.9	193.5	78.4	390.8	1.9	98.8	25.9	25.9	170.7	113.2

TABLE I(a)—Staff of the school health service as at 31 December 1970

	Medical officers						Nurses and health visitors						Speech therapists							
							With health visitors' certificate		Without health visitors' certificate		Nurses' assistants									
	Solely school health service	Part-time school health service/rest of time local health service	Part-time school health service/rest of time as general practitioner	Part-time school health service/rest of time on other medical work	Ophthalmic specialists	Other consultants and specialists	Employed solely in clinics	Employed in clinics and elsewhere	Employed solely in clinics	Employed in clinics and elsewhere	Employed solely in clinics	Employed in clinics and elsewhere	Senior speech therapists	Speech therapists	Assistant speech therapists	Audiometricians	Chiropodists	Orthoptists	Physiotherapists	Others (excluding clerical staff)
Number:																				
England																				
Full-time	113	942	—	7	3	—	19	4055	73	1135	72	222	65	270	1	79	58	10	116	100
Part-time	71	792	695	449	253	193	1	2295	97	1110	55	268	25	345	4	66	168	53	165	90
Wales																				
Full-time	3	114	—	11	—	—	1	437	3	132	—	13	5	13	1	3	—	—	1	2
Part-time	2	40	23	18	8	3	—	66	4	70	—	12	2	12	—	5	2	3	2	—
Total																				
Full-time	116	1056	—	18	3	—	20	4492	76	1267	72	235	70	283	2	82	58	10	117	102
Part-time	73	832	718	467	261	196	1	2361	101	1180	55	280	27	357	4	71	170	56	167	90
Whole-time equivalent:																				
England	134.5	687.2	85.1	80.6	55.7	17.2	5.8	1729.8	78.9	1270.3	69.7	272.9	78.8	396.8	4.8	101.9	31.4	25.9	166.7	123.4
Wales	3.1	57.2	2.9	7.1	7.0	0.1	0.5	165.9	3.3	58.4	—	12.5	5.8	17.1	1.0	4.4	0.3	1.2	1.5	0.7
Total	137.6	744.4	88.0	87.7	62.7	17.3	6.4	1895.7	82.2	1328.7	69.7	285.4	84.6	413.9	5.8	106.3	31.7	27.1	168.2	124.1

TABLE II—Medical staff of the school health service in England and Wales

	1950		1955		1960		1965		1969		1970	
	No	FTE	No	FTE	No	FTE	No	FTE	No	FTE	No	FTE
Solely SHS	241	227.45	198	196.54	186	184.88	159	143.6	186	138.4	189	137.6
SHS/LHS	1246	573.93	1477	653.91	1670	690.75	1814	765.81	1787	659.5	1888	744.4
SHS/GP	501	105.69	578	95.47	588	83.14	803	127.42	726 (1231)	92.0 (183.0)	718	88.0
SHS/Other									505	91.0	485	87.7
Total (rounded)	1988	907	2253	946	2444	959	2776	1037	3204	981	3280	1057.7
Ophthalmic specialists	Not available		Not available		Not available		265	56.15	258	55.8	264	62.7
Other consultants and specialists	Not available		Not available		Not available		188	18.67	201	18.3	196	17.3

TABLE III—Maintained school population, medical officers, and medical inspections, in England and Wales

	1950	1955	1960	1965	1966	1967	1968	1969	1970	
Nursery*	22	23	24	28	29	31	32	34	36	As at
Primary*	4005	4593	4136	4377	4509	4664	4812	4942	5059	following
Secondary (000s)	1733	2057	2829	2817	2833	2895	2964	3046	3144	Jan.
Special*	40	50	58	67	69	73	76	78	82	
Total (000s)	5800	6723	7047	7289	7440	7663	7884	8100	8321	
SMO (FTE)	907	946	959	1037	949	931	1035	981	1058	At
Pupil per FTE SMO	6394	7106	7348	7028	7839	8230	7617	8257	7865	Dec.
Medical Inspections (000s):										During the
1. Routine	1876	2132	2112	1887	1892	1870	1803	1797	1786	calendar
2. Special and re-inspection	2582	2215	1762	1478	1393	1364	1291	1215	1179	year
(1) As % of total school pupils	32	32	30	25	25	24	23	22	22	

* Includes part-time pupils.

1. No pupil is included more than once.
2. The same pupil may be included more than once.

TABLE IV—Nurses and health visitors in the school health service

	1955	1960	1965*	1966	1967	1968	1969*	FTE	1970 No	1970 FTE	1970 No
No of nurses	With HV cert. 4561	5466	6121	6186	6215	6574			6679		6874
	Total no. nurses 6276	7150	8129	8499	8801	9467			9318		9498
FTE			In clinics 1060.41	904.22	871.55	830.9	Solely in clinics with HV Cert	13.0	26	6.3	21
							Solely in clinics without HV Cert	116.8	215	82.2	177
			Other than clinics 2062.58	2024.32	2001.43	2187.9	Clinics and elsewhere with HV Cert	1999.0	6653	1895.7	6853
							Clinics and elsewhere without HV Cert	1205.8	2424	1328.7	2447
Total FTE	2548.36	2637.19	3122.73	2928.80	2872.98	3018.8		3334.6		3312.9	
No. of nurses Ass. and Trainee	378	400	627	636	569	534			451		642
FTE			In clinics 184.25	160.67	148.84	154.8	Solely in clinics	37.9		69.7	
			Other than clinics 134.52	156.35	136.40	124.8	Clinics and elsewhere	193.5		285.4	
Total FTE	244.40	242.40	318.77	317.02	285.24	279.6		231.4		355.1	

* In 1965 and 1969 the form of the returns was changed.

TABLE V—Special schools and pupils, January 1970

Category of School	Maintained					Non-maintained					Total					Total pupils
	Schools		Pupils‡			Schools		Pupils‡			Schools		Pupils‡			
	D	B	D	B		D	B	D	B		D	B	D	B		
				d	b				d	b				d	b	
Blind		2		10	152		15		17	797		17		27	949	976
Partially sighted	15	1	942		296		4		23	303	15	5	942	23	599	1564
Blind and partially sighted		1		13	104		1		2	118		2		15	222	237
Deaf	7	5	560	77	195		7		188	947	7	12	560	265	1142	1967
Partially hearing	1	3	60	6	240		2		19	227	1	5	60	25	467	552
Deaf and partially hearing	11	7	1079	388	310		6		76	710	11	13	1079	464	1020	2563
Deaf and partially sighted		1		13	161							1		13	161	174
Physically handicapped	32	23	3082	339	1040	1	23	69	189	975	33	46	3151	528	2015	5694
Delicate	22	28	2704	175	1695		8		1	549	22	36	2704	176	2244	5124
Delicate and physically handicapped*	61	3	5146	31	94		2			210	61	5	5146	31	304	5481
Delicate and maladjusted	1	3	100		297		1			48	1	4	100		345	445
Maladjusted	39	53	1438	103	1739		18			770	39	71	1438	103	2509	4050
Educationally sub-normal	343	120	42448	2337	7495	1	14	136	96	1224	344	134	42584	2433	8719	53736
Epileptic		2			107		4			497		6			604	604
Speech defect		1		6	7		2			85		3		6	92	98
Multiple handicaps	2	1	52		25						2	1	52		25	77
Hospital†	80		2866			9		639			89		3505			3505
Total	614	254	60477	3498	13957	11	107	844	611	7460	625	361	61321	4109	21417	86847

* The pupils in this column include 118 partially sighted, 1 deaf, 56 partially hearing, 61 educationally sub-normal, 321 maladjusted, 194 epileptic, 114 speech defect pupils attending schools for the delicate and physically handicapped.
† Hospital schools have been regarded as day schools.
‡ Pupils residing in approved boarding homes or with approved foster parents have been regarded as day pupils.
D=day, B=boarding, d=day pupils in boarding schools, b=boarding pupils in boarding schools.

TABLE V(a)—Special schools and pupils, January 1971

Category of School	Maintained					Non-maintained					Total					Total pupils
	Schools		Pupils†			Schools		Pupils†			Schools		Pupils†			
	D	B	D	B		D	B	D	B		D	B	D	B		
				d	b				d	b				d	b	
Blind	—	2	—	11	163	—	15	—	26	779	—	17	—	37	942	979
Partially sighted	15	1	1024	1	300	—	3	—	28	296	15	4	1024	29	596	1649
Blind and partially sighted	—	1	—	13	102	—	1	—	—	122	—	2	—	13	224	237
Deaf	8	5	726	95	204	—	7	—	165	970	8	12	726	260	1174	2160
Partially hearing	1	3	76	11	230	—	2	—	23	236	1	5	76	34	466	576
Deaf and partially hearing	10	7	980	404	285	—	5	—	82	552	10	12	980	486	837	2303
Deaf and partially sighted	—	1	—	15	158	—	—	—	—	—	—	1	—	15	158	173
Physically handicapped	28	23	2566	494	999	2	22	167	201	883	30	45	2733	695	1882	5310
Delicate	19	30	2192	123	1794	—	7	—	—	479	19	37	2192	123	2273	4588
Delicate and physically handicapped	64	6	5582	239	168	—	2	—	—	221	64	8	5582	239	389	6210
Delicate and maladjusted	1	2	99	—	230	—	1	—	—	46	1	3	99	—	276	375
Maladjusted	45	58	1771	101	1917	1	16	30	—	663	46	74	1801	101	2580	4482
Educationally sub-normal	364	128	44873	2890	7679	1	14	139	244	1099	365	142	45012	3134	8778	56924
Epileptic	—	2	—	—	96	—	4	—	—	494	—	6	—	—	590	590
Speech defect	—	1	—	7	11	—	2	—	—	85	—	3	—	7	96	103
Multiple handicaps	3	—	165	—	—	—	—	—	—	—	3	—	165	—	—	165
Hospital*	77	—	2939	—	—	9	—	598	—	—	86	—	3537	—	—	3537
Total	635	270	62993	4404	14336	13	101	934	769	6925	648	371	63927	5173	21261	90361

* Hospital schools have been regarded as day schools.

† Pupils residing in approved boarding homes or with approved foster parents have been regarded as day pupils.

D = day, B = boarding, d = day pupils in boarding schools, b = boarding pupils in boarding schools.

TABLE VI—Statistics of dental officers

Year	Dental officers (salaried and sessional)				Dental officers—sessional only	
	Number	Whole-time equivalent				
		SDS	M and CW	Total	Number	WTE (including M and CW)
1950	864	717	—	717	—	—
1955	1488	1008	—	1008	—	—
1960	1612	1030	—	1030	—	—
1965	1830	1244	86	1330	696	234
1966	1810	1246	88	1335	680	238
1967	1821	1272	92	1364	677	232
1968	1882	1316	101	1417	703	247
1969	1914	1326	96	1422	733	254
1970	1942	1357	104	1461	714	245

APPENDIX G (Chapter 6)

MAIN STATUTORY PROVISION FOR THE SCHOOL HEALTH SERVICE, FOR SERVICES REQUIRING THE USE OF SCHOOL MEDICAL OFFICERS, AND FOR THE SPECIAL EDUCATION AND CHILD GUIDANCE SERVICES

I. THE SCHOOL HEALTH SERVICE AND ASSOCIATED MEDICAL SERVICES

Education Act 1944

Section 48	(1)	Lays a duty on LEAs to provide for the medical inspection of pupils at maintained schools and a power to provide for the inspection of senior pupils (aged 12 years or over but under 19) at other maintained educational establishments.
	(2)	Obliges parents to allow school pupils to be medically inspected, and other pupils to agree to medical inspection and lays down a maximum penalty for unreasonable refusal of £5.
	(3) and (4)	Give LEAs a duty in the case of school pupils, subject to their parents consent, and a power in the case of other pupils to ensure that free medical treatment is available, and that pupils are encouraged and assisted to avail themselves of this. [These duties and powers are qualified by Section 7(4) of the NHS Act 1952.]
	(5)	Ensures that voluntary schools provide facilities for LEAs to carry out their functions under section 48.
Section 78	(1)	As amended by the Education Act 1953, enables LEAs to arrange for the medical inspection or medical or dental treatment of a pupil for whom the authorities have made special arrangements for education otherwise than at school.
	(2)	Enables LEAs to make arrangements on agreed terms for the medical inspection and medical or dental treatment of pupils in independent schools, provided the cost to the LEA is no greater than it would be for a pupil in a maintained school.
Section 114		As amended by the Education Act 1953 precludes an LEA from providing medical treatment in a pupil's home unless they have arranged that the pupil will be educated otherwise than at school.
Section 69		Enables the Secretary of State for Education and Science to make regulations about the conduct of medical examinations etc. and the qualifications of medical practitioners; and also to require an independent medical examination in the case of an appeal to the Secretary of State.

Section 54		Gives LEAs the power to authorise a medical officer of the authority to see that "the persons and clothing" of pupils at school are examined; sub-sections provide for action to ensure cleanliness being taken immediately and for pupils being excluded from school until it has been taken.
Section 59		Makes provision to prevent the health of school pupils being prejudiced by employment.

Education (Miscellaneous Provisions) Act 1953

Section 4		Requires LEAs to provide comprehensive facilities for the free dental treatment of school pupils in maintained and voluntary schools, and power to provide free dental treatment for pupils at any other maintained educational establishment. The treatment can be provided either directly by the LEA or by arrangement with the hospital service; or by both.

Education (Milk) Act 1971

Section 1	(1)(b)	Provides for LEAs to supply free school milk for a child aged between 7 and 12 on a certificate supplied by a school medical officer.

Employment Medical Advisory Service Act 1972

Section 1	(6)	Requires LEAs to arrange for one of their officers who is a fully registered medical practitioner to provide, on the application of an employment medical adviser, relevant particulars of the school medical record of, and other medical information about, a young person under 18.

The School Health Service Regulations 1959 (as amended in 1965, 1966 and 1968)

Require LEAs to maintain a "school health service" which shall include a "school dental service" and to appoint a principal school medical officer, and principal school dental officer, and such other medical and dental officers, nurses and others persons as are necessary.

There are requirements that subject to certain savings a school nurse shall be a qualified health visitor, and also requirements that those employed from "the professions supplementary to medicine" shall be registered by their professions.

They provide that parents shall be given an opportunity to be present at medical inspections and at the first dental inspections.

They provide for the keeping of medical and dental records for every pupil.

The Medical Examinations (Sub-Normal Children) Regulations 1959

Require special qualifications for those who carry out medical examinations to assess whether children should be educated in schools for the educationally or the severely sub-normal.

The Handicapped Pupils (Boarding) Regulations 1959

Include provision for the LEA to supervise the medical and dental care of handicapped pupils in a boarding home.

The Training of Teachers Regulations 1967

Requires students admitted to teacher training to be of good health and physical capacity for teaching (it is usual for a medical report to be provided through the PSMO of the pupil's home authority).

The Schools Regulations 1959

On first appointment to maintained schools, special schools or direct grant schools (other than grammar schools) teachers are required to satisfy the Secretary of State for Education and Science of their health and physical capacity for teaching.

Employing authorities are required to notify the Department of any teachers developing certain diseases which may necessitate their suspension, or the attachment of conditions to their employment, on medical grounds.

II. SPECIAL EDUCATION

Education Act 1944

Section 8 (1) Requires that all pupils shall be afforded opportunities for education "offering such variety of instruction and training as may be desirable in view of their different ages, abilities, and aptitudes, and of the different periods for which they may be expected to remain at school, including practical instruction and training appropriate to their respective needs".

(2) Requires that LEAs shall have regard . . . "(c) to the need for securing that provision is made for pupils who suffer from any disability of mind or body by providing, either in special schools or otherwise, special educational treatment, that is to say education by special methods appropriate for persons suffering from that disability".

Section 33 (as amended by Education Act 1948). Gives power for regulations to be made to define the categories of pupils requiring special educational treatment and to make provision for special methods for their education, for special education to be provided in special or ordinary schools and for the approval of special schools.

Section 34 (1) (as amended by the Education Act 1946). Requires LEAs to (2) ascertain what children require special educational treatment and empowers them to require parents to submit children of over the age of 2 for examination by a medical officer of the authority for advice about "whether the child is suffering from any disability of mind or body and as to the nature and extent of any such disability"; parents may also request a medical examination for children over the age of 2.

(3) enables parents to be present at the examination;
(4) requires the LEA to reach a decision about the need for special education after considering the advice of the medical officer and any other reports from teachers or others and to arrange for the special educational treatment to be provided unless the parents themselves make suitable arrangements;
(5) provide a machinery for parents to appeal to the Secretary of
(6) State against a decision that a child requires special educational treatment.

Section 56 Enables LEAs to arrange for children to be educated other than at school, be it at home, or at hospital.

Section 57 Which provides for the classification of children as unsuitable for school has been repealed by the Education (Handicapped Children) Act 1970.

III. THE CHILD GUIDANCE SERVICE

Powers to provide clinics are derived from section 48 (3) and section 34 of the Education Act, 1944.

APPENDIX H (Chapter 6)

PAPER BY THE ASSOCIATION OF EDUCATION COMMITTEES, THE ASSOCIATION OF MUNICIPAL CORPORATIONS, THE COUNTY COUNCILS ASSOCIATION, THE INNER LONDON EDUCATION AUTHORITY AND THE WELSH JOINT EDUCATION COMMITTEE, (MARCH 1971)

SCHOOL HEALTH SERVICE

At a meeting at the Department of Education and Science on the 15th January, 1971, representatives of the local authority organisations listed above expressed concern about the future of the School Health Service. They suggested that, as a matter of urgency, there should be a joint study to consider how the continuance of the School Health Service and its development can be ensured. (A summary of the submissions made to the Department is reproduced below.)

The Departmental representatives acknowledged the need for a study of the problems involved and agreed that the submission of a local authority paper would be helpful. It was further suggested and agreed that this should include a definition and evaluation of the existing and prospective functions of the School Health Service, and outline the local authority view both on the problems facing the Service following reorganisation of the National Health Service and on arrangements for ensuring its continuance and development as part of a re-organised National Health Service outside local government. The proposed paper is set out under I and II.

A SUMMARY OF THE SUBMISSIONS MADE TO THE DEPARTMENT

1. That the Associations regret the Government's decision to unify the administration of the health services outside local government.

2. That the Associations are far from confident that the expectations set out in paragraphs 32 and 33 of the previous Administration's Green Paper, regarding the future of the School Health Service, will be realised.

3. Having regard to experience of the need for integration of the School Health Service with the Education Service as a whole, the Associations believe that an assessment should be made of the effect of the proposed reorganisation on the School Health Service and in particular that there is an urgent need for a detailed study of the many professional, administrative and financial factors involved.

4. That, for the purposes of this study, an attempt should be made without delay to define and evaluate the existing and prospective functions of the School Health Service.

5. That, in particular, this first part of any such study should deal separately with the importance of the Service for the prevention of ill-health (the detection and treatment of ill-health, assessment of and advice on physical and mental handicaps affecting the education of individual children, health education, the dental service and the occupational health service provided in respect of teachers where, as in depressive conditions, for example, the well-being of the pupils must be taken into account equally with the health of the teacher.

6. That Part II of the study should deal with the problems involved in ensuring the continued development of the School Health Service as envisaged in Part I.

7. That, as the links between the School Health Service and local government are clear and can be defined on the basis of existing practice, there may be advantage in dealing with the School Health Service separately, in the first instance, before embarking on the more complex study required in respect of future relationships between local government and the National Health Service as a whole.

8. That in dealing with the question of relationships affecting the School Health Service, special consideration will be needed as to arrangements for

(a) determining policies, e.g. by arranging for the submission of agreed proposals to the appropriate Government Departments for confirmation;
(b) resolving differences as to policies and priorities as between area health and local authorities;
(c) finance, as between area health and local authorities;
(d) ensuring acceptable performance of agreed policies, e.g. suitable default provisions;
(e) ensuring adequate involvement in matters of joint concern, including appointments; and
(f) encouraging close working relationships of the kind which exist at present between school medical officers and the teaching staff of the schools.

9. That the Associations will be willing to co-operate fully in carrying out the study outlined above, but would wish to reserve their position on the outcome.

10. That, in particular, if the results of the study are unsatisfactory, the Associations might wish to reserve the right for local education authorities to appoint such staff as may be necessary to ensure an effective School Health Service.

11. That, in the meantime, the Associations wish to stress the importance they attach to the need (a) to ensure that the contribution, both direct and indirect, made by the School Health Service to the education process is encouraged to continue to develop and (b) to reverse any tendency for the Service to run down as a result of uncertainty as to the future; in the opinion of the Associations, the dissipation of the enthusiasm and skills which have been built up in the School Health Service, particularly over the past twenty years, would constitute an incalculable loss to education and the country's health.

I: THE EXISTING AND PROSPECTIVE FUNCTIONS OF THE SCHOOL HEALTH SERVICE

The medical and social developments of the last twenty-five years have reshaped some of the needs which the Service was designed to meet such as massive malnutrition and infectious diseases and infestations. Nevertheless, the staff engaged in the Service carry out many more functions now than ever before, including:

1. The early detection of handicap.

2. The examination and screening of children throughout school life to discover defects at an early stage of their development and arrange for appropriate treatment, This includes work in nursery classes and centres and schools for children with many kinds of handicap.

   Conditions such as hearing loss and visual defects would not be detected readily by other medical agencies.

   Once defects have been discovered the Service is responsible, in co-operation with teachers of the deaf and others, for ensuring that the child wears spectacles, hearing aids, etc., regularly and that both parents and children are trained in the proper use of the equipment.

   Continuing advice to Chief Education Officers on a handicapped child's needs in relation to his education.

3. The investigation of school absences when it is suspected that these are due to emotional or physical causes.

4. Investigation of the remaining infections and infestations to reduce spread and provide appropriate treatment. Prevention of infectious diseases by an increasing range of immunisation procedures. Much of this work is done by the school nursing service, which is also a very important link between the school and the home.

5. Oversight and advice on environmental hygiene in the schools including safety precautions in laboratories—where health hazards are possible—and the special environmental needs of handicapped children.

6. Close liaison with the various agencies on the placement of the handicapped school-leaver.

7. Advice and participation in health education in schools and colleges of education. In this sphere joint advisory bodies of teachers, educational advisers, medical officers, and health education officers have a vital part to play in organising courses and programmes of health education to meet the various needs.

8. Advice to chief education officers on the health of teachers and other educational staff where it is likely to affect the pupils, and the examination of entrants to the profession. The school medical officer has to interpret medical reports in terms of the practicalities within the school and college situation and to advise on priorities, especially where different referral agencies are involved.

9. In the school dental part of the Service the provision of a comprehensive dental inspection and treatment service for school children, with an emphasis on the prevention of dental disease. The School Dental Service exists to guarantee dental care for those classes of the child population which stand in most need for it. This is clearly most conveniently fulfilled by dental inspections in schools and this requires very close relations with teachers, as well as parents, within the school organisation.

10. Provision of other services for children, e.g., speech therapy, physiotherapy in a school-orientated setting so that there is a positive integration with education and as little time as possible is lost from school.

11. The maintenance of close contact with colleagues responsible for the child during the pre-school years and with family doctors and other medical specialists, social agencies, and educationalists.

This is by no means an exhaustive list of functions which may be summarised as being directed to ensure that the child is enabled to reap the full benefit from the educational system, and to ensure that illness, disability, or handicap does not prejudice a child educationally, or his later functioning as an adult.

This somewhat restricted summary, with its emphasis on the detection and amelioration of defects so readily carried out in a "captive" group such as school children, reflects the general pattern of the Service from its inception. There is no prospect of these important needs being met by an existing service other than the School Health Service, whose personnel are the only ones with an adequate training.

The service is now moving into a broader important sphere—the prevention of ill-health in childhood. Whilst scientific and medical advances, periodic assessments and screening procedures will help to find the defects at an earlier stage, and increasing knowledge of genetics, metabolism, etc., will prevent some defects happening, there is an increasing awareness that much of the mental ill-health of childhood could be prevented.

Recent reports on the incidence of emotional problems in school life have revealed the extent of the problem. Medical, social and educational factors are all involved—many children becoming severely disturbed as a result of educational failure. Close co-operation between the school medical officer and the teacher should result in a co-ordinated approach to the individual child. Placement of a child in any form of special education and ongoing review of his needs should be as a result of joint discussions between the educational and medical staff, taking into account all the child's individual needs. Barriers between the professions are steadily breaking down.

The service has not yet fulfilled its potential in the sphere of research into child health in general. As a normal part of its work it acquires a great body of information not otherwise available, and opportunities exist to extend the value of this in the preventive field. Work needs to be carried out in particular subjects, for example, emotional disturbance in young children, obesity of childhood, subacute and chronic infections, and the multiple problems of adolescence.

Extension of the work to include the problems of student health in colleges of education, technical colleges and other establishments for further education is another potential field.

The practice of school medicine differs from other clinical practice in that:

1. It attempts to be preventive; discovering unrecognised early deviations from normal and advising on treatment.
2. It is concerned with a developing organism—the child. The approach is that of developmental paediatrics rather than treatment of frank disease.
3. It is particularly related to a specific environment—the school—and a detailed knowledge of this environment is essential.

There are therefore very cogent reasons why the School Health Service should continue as a specialised service but this must retain close links with the medical services concerned with community preventive health. The school child cannot be considered as a separate entity from the pre-school child or the adolescent in employment.

The concept of the "school physician" as a doctor intimately associated with school life is therefore becoming fairly clear. There must be close involvement with the assessment of the pre-school child's development. Although there may be administrative divisions between the pre-school and the school child, in practice in the field most of the medical staff are concerned with both age groups. The medical officers also receive reports from family doctors, consultants, and other agencies and should be able to give valuable information about the child on entry into school, particularly in respect of those "at risk" of educational difficulty for physical, emotional, social or limited intellectual reasons.

Throughout school life the school physician must continue a close watch on the child's development and educational placement and help in preparation for the transfer from school to life and employment in the community.

Apart from close co-operation with the environmental health services, there must be close links with general practitioners and paediatricians so that the effects of acute illness can be equated to future educational problems and early remedial advice given. There are already signs of increasing co-operation in this sphere.

II. FUTURE ADMINISTRATIVE ARRANGEMENTS

1. The School Health Service was not mentioned in the previous Administration's first Green Paper on the Reorganisation of the National Health Service and was only briefly referred to in their second Green Paper.

The local authority organisations are concerned to ensure the continued development of the school health services following any reorganisation of the National Health Service outside local government. Accordingly, they have attempted to identify some of the practical problems involved with a view to formulating outline proposals as the basis for discussions with the Departments concerned. They appreciate the need for any new administrative framework to be generally acceptable to the many interests involved. For that reason, the following notes are intended simply as an indication of the general direction of local authority thinking. They will welcome the opportunity to develop their proposals at an early date. The local authority organisations regret the Government's decision to unify the administration of the National Health Service outside local government, but their approach to the problems which will ensue is essentially positive and constructive.

2. The scope of the School Health Service, as outlined in Part I above, exceeds the functions of consultants and general practitioners both clinically and administratively. Although some clinical work formerly undertaken by the School Health Service is now being carried out by consultants and general practitioners, there is no foreseeable prospect of their being able to provide the whole range of existing and prospective services comprised in the School Health Service. The suggestion in the second Green Paper that the Service will be provided "by doctors, especially paediatricians" and others is unrealistic. In particular, consultant paediatricians (of whom there were only 279 in England and Wales in September, 1969) are hospital-based, deal with acute episodes of ill-health and, in practice, have restricted opportunities for gaining experience of the educational and emotional problems of the child within the community. The clinical aspects of the service, under a reorganised National Health Service, have been the subject of discussion in a recent paper prepared by the Council of the School Health Service Group of the Society of Medical Officers of Health called "The Future of the School Health Service". They note that the clinical aspects of the Service involve co-operation with a wide variety of specialists including paediatricians, ophthalmologists, E.N.T. surgeons, child psychiatrists and orthopaedic surgeons, and their considered view, with which the local authority organisations concur, is that neither general practitioners nor paediatricians can undertake all the work involved. For ease of reference, an extract from their paper is set out in the Annexe.

3. The concept of systematic prevention necessarily involves administrative and managerial functions. For the exercise of these as compared with the clinical functions referred to above, many individual consultants and general practitioners will be even less well placed, by way of training, experience, aptitude and opportunity. The local authority organisations see no prospect of the complex of services currently provided by the School Health Service being continued, still less developed, except under arrangements made specifically and systematically for that purpose.

4. For example, the School Health Service is concerned with the whole range of children and literally provides a health service, not an illness service. General practitioners and consultants, on the other hand, tend only to see those patients who present themselves for treatment. If left to chance, i.e. to random initiatives taken by individual general practitioners and consultants, the service would be a shadow of that which exists today. Similarly, School Health Service doctors and nurses working with school children must establish satisfactory working relationships with their teachers. It is very doubtful whether hospital consultants can be expected, in any foreseeable future, to have the opportunity or inclination to establish such relationships. General practitioners might find this possible in some areas, but overall the result would, at best, be uneven.

5. At present, the School Health Service combines a reasonable degree of uniformity with capacity to adapt to changing conditions. But unless there is some provision for systematic administration by a Principal School Medical Officer or other trained medical administrator any future School Health Service will amount to no more than the aggregate of whatever initiatives may, or may not, be taken by individual doctors. Systematic administration of the School Health Service is in no way inconsistent with the independent professional status of consultants

and general practitioners, although the local authority organisations do not underrate the difficulties involved in devising generally acceptable arrangements. Administratively, co-ordination can be secured without any real difficulty where, as in the existing School Health Service, doctors are employed in a hierarchical structure under contracts of service; it is to be hoped that, under whatever arrangements replace this in the reorganised National Health Service, the co-ordination which the previous Administration's Second Green Paper assumed, will be found, following study of the problems involved, to be achievable in practice.

6. But, even assuming that the Government is able to devise arrangements which are both acceptable to professional interests and effective, it is important to recognise that the medical administrators will not simply be required to exercise a co-ordinating function. First, they will also need to provide supplementary and supporting services. For example, the hazards of cigarette smoking are now well-established and many chest physicians do much to help their patients on this count. But it would be a mistake to assume that chest physicians, generally, have the opportunity, or know best, how to approach school children on the question of smoking and health, or how to organise a suitable health education campaign. Similar considerations apply with regard to drugs.

7. Secondly, the pioneering work of the Service has been, and should continue to be particularly valuable. Progressively it has taken on new and expanding functions some of which have been taken over by general practitioners and others, as the need for them has come to be accepted generally. In general terms, this is illustrated in the School Health Service by the gradual change in emphasis from the detection of maladies to the prevention of ill-health and the assessment of educational need. The managerial function must include identifying and providing for new and growing areas of need. Principal School Medical Officers and LEAs jointly play essential parts in this process.

8. Having regard to these factors, the local authority organisations have concluded that the Statute reorganising the National Health Service must make specific provision for the School Health Service in such a way as to ensure that an effective relationship between health and local education authorities can be established and maintained and, in particular, that the functions of the medical administrators concerned are clearly defined.

9. The following paragraphs are intended primarily to indicate the kind of basis on which it should be possible to build a satisfactory administrative structure.

10. It is a truism that, although it is possible to divide health, social and educational services administratively, in practice the needs of many are the joint concern of more than one service. The recruitment and career structure problems involved in employing professional staff divorced from the main stream of their professions are obvious. But other important problems arising from the re-organisation of the National Health Service outside local government have not so far received sufficient attention. These include the need not only to ensure that resources are not wasted as a result of unnecessary duplication, but also to avoid gaps between services and, so far as possible, to see that the separate services are co-ordinated.

11. These are not new problems. They exist now, for example, in respect of the two branches of the National Health Service which are at present outside local government. But the problems, in spite of arrangements for local joint consultation, have not been resolved satisfactorily, and with the growing emphasis on planned early discharge from hospital and care in the community, their solution is becoming more urgent. The complete separation of all three branches of the National Health Service from local government underlines the need for and indeed demands a fresh approach, not only in relation to the School Health Service but in other fields as well. Experience suggests that joint consultation and even its logical extension, i.e. joint representation on committees, are unlikely in themselves to lead to effective co-ordination. There must be more than token consultation if the time of hard-pressed members of authorities, doctors, teachers and administrators spent in this way is to be justified.

12. Similarly, the suggestion that has been widely canvassed, that the Medical Officer of Health, Community Physician or other medical administrator of the future should have "consultant status" will not in itself achieve anything. "Consultant status" may confer some sort of parity for professional and pay purposes, but the new situation will require medical administrators with a managerial function and considerable supporting staff and for that purpose, as the "Cogwheel Report" has shown, the suggestion is irrelevant.

13. For the reasons indicated in paragraphs 2, 4 and 6, specialist staff will be required in the School Health Service and these will need to be administratively accountable to the medical administrator. But it would be unrealistic to think in terms of either his fellow consultants or the general practitioners in his area being similarly accountable. In practice, co-ordination within the National Health Service is likely to depend on agreement as to objectives and control of finance and it is these areas which must be considered in attempting to achieve co-ordination as between the National Health Service and local government.

14. It is a commonplace of discussion of the future of the National Health Service to speculate on the difficulties of securing adequate resources for the development of "prevention" with its long-term saving of life, in the face of shortcomings in hospital departments where, in terms of life and death, more staff and finance can sometimes have immediate effect. The local authorities believe that it is better for these long-standing problems as to priorities, difficult as they undoubtedly are, to be acknowledged, rather than continue to be obscured by administrative divisions. But they are concerned about how the decisions as to priorities are made and their effect generally on relationships between local and health authorities and, in particular, on the future of the School Health Service. This paper is concerned with the School Health Service and not with the wider questions of composition and the accountability of the future health authorities or their general relationships with local authorities. The local authority organisations understand that these will be the subject of further consultations when the Government publish revised proposals.

15. It is not difficult to visualise a situation where, in allocating resources, separate administrations give priority to services which come indisputably within their respective provinces, without making adequate provision for grey

areas. Potentially, the School Health Service is such an area. In the abstract, there may well be general agreement as to its value, but in practice, in the context of health authority administration, there will often be other priorities thought to be more pressing. And even if the Medical Officer of Health, Community Physician or medical administrator is fully seized of the value of the service, it would be unrealistic to assume that his "fellow consultants" will accept his assessment.

16. In default of a unified administration, the solution which the local authority organisations have in mind is to establish at the outset a joint approach as between Health and local authorities. The School Health Service is only one of a number of areas of common concern, where the services provided by the separate administrations are complementary. The local authority organisations suggest, therefore, as a basis for discussion, that health and local authorities should be required to confer and prepare agreed proposals as to the development of their respective services in so far as they are of mutual concern. The discussions would need to be undertaken in the knowledge that many of the objectives of each of the two types of authorities cannot be achieved except in partnership. In the case of the School Health Service, it will be the local authority which primarily depends on the health authority, but in the case of other services the health authority will be dependent on the local authority, e.g., for social, educational and other services for hospital and general practice patients remaining in, or returning to, their own, or local authority homes. Such mutual dependence should provide reasonable scope for give-and-take and should largely avoid the need for the reference of differences to the Secretary of State or the exercise of default powers. Similarly, it should be possible to avoid complex and unproductive accounting procedures for costing and payment for services. The definition of objectives in areas of common concern would take account of any priorities determined nationally by the Secretaries of State concerned, but detailed Ministerial control would be unnecessary, particularly where agreement between health and local authorities was complete. Similarly, the precise dividing lines agreed locally as between one service and another could be determined in the light of local circumstances and be adjusted from time to time in the light of developments. For example, so long as the health, education and social service components of the child guidance service co-operated effectively it is questionable whether there would be any need for a national decision as to professional primacy. Provision would be needed in any event for local education authorities to continue to run a child guidance service in conjunction with the school psychological service. It will also be necessary, so that local education authorities may have access to expert medical advice as of right on matters affecting the health, education and care of school children and students, for the chief medical officer of a health authority to have a statutory responsibility to report to and advise the appropriate education authority. Special arrangements will be necessary where areas of education and health authorities are not co-terminous.

17. Joint consultations of the kind visualised by the local authorities would necessarily lead to close, mutual involvement in services of mutual concern. This would not be achieved by a simple, statutory requirement to prepare once-for-all proposals in general terms. These would need to indicate more or less

precisely both joint objectives and the contributions which each authority had undertaken to make in reaching them. Such proposals would necessarily require continuous up-dating in the light of developments, and the dialogue between health and local authorities would correspondingly need to be on a continuing basis.

18. Arrangements, for example, for the joint use of computer installations and other services, would be subsidiary to the main purpose but could make important contributions to the efficient use of resources. If such subsidiary proposals were not proceeded with, services to the public would not be seriously impaired, but unless arrangements can be made for effective co-ordination of health and education services, the School Health Service may, effectively cease to exist.

ANNEXE

EXTRACT FROM PAPER ENTITLED "THE FUTURE OF THE SCHOOL HEALTH SERVICE", PREPARED BY THE COUNCIL OF THE SCHOOL HEALTH SERVICE GROUP OF THE SOCIETY OF MEDICAL OFFICERS OF HEALTH

Discussion:

Some may say that many of the above duties are already being done and in some instances this may be so, but in general an important change of approach is required. It is insufficient to find something wrong and report this to a specialist. It is essential that the abnormality be considered in relation to all aspects of the child's education. For this, specialised training is required.

We should give thought not only to the way in which school medicine will be practised in the future but to those who will staff the service and to their training. Some have seen the general practitioner playing the predominant clinical role.

Thus the Gillie Report (1963) reads:

"As family doctors find an increasing interest in the environmental circumstances of their patients, they will participate more fully in clinic work among those groups which are the responsibility of health departments. The number of full-time doctors in health departments should then decrease considerably. Those remaining would be largely specialist administrators . . ."

The Chief Medical Officer in "The Health of the School Child" (1964) commented on the Gillie Report thus:

"General practitioners who are prepared to accept the conditions of working in the School Health Service, particularly keeping appointments in schools, arriving on time and working a full session, make a valuable contribution to the service and add to the completeness and satisfaction of their work."

There are both advantages and difficulties in general practitioners carrying out school medical examinations. In our opinion some could well be employed in schools, but it is essential for them to have adequate training, to be interested in the subject and to be able to devote the necessary time to it. Such a state of affairs may well be helped by the growth of group practices and the recognition of child health as a specialty in general practice in the same way as obstetrics and opthalmology are so recognised. Married women doctors and part-time medical officers may well continue to be employed, but adequate training is essential before the assumption of clinical responsibility. Such doctors would be responsible for many of the duties listed.

Over and above these duties, there is a need for a clinical specialist to be medically associated with paediatricians and child psychiatrists but having a good knowledge of special educational treatment, special schools and the services rendered by social agencies and voluntary societies.

To some extent this need may be implied in the memorandum of the Chief Medical Officer on "Comprehensive Assessment Centres for Handicapped Children" (1968)—"A significant amount of responsibility for on-going assessment falls therefore on the local authority medical staff".

"The cornerstone of a successful community service for the handicapped child is a working medical partnership between the consultant paediatrician and a local

authority medical officer with particular experience of handicapped children. The latter will enhance the work of the assessment centres with specialist knowledge of local services and conditions, and bring together the contribution of other officers in the local authority caring for any particular child. Attachment of the selected medical officer should be on a permanent basis to ensure continuity."

In our view the work of the officer acting in this capacity is not as an administrator but a clinician with clinical responsibility.

He should examine children who are failing educationally, to diagnose and assess any physical factors which may be relevant. For this he will require not only a sound knowledge of child psychology and psychological tests but an understanding of the ways in which the results of tests may be affected by physical, developmental and social factors. We do not see psychometric testing as the responsibility of the child health specialist, although he must be prepared to estimate motor, language and articulation development, and to look for pathological states if these are significantly abnormal. An intimate acquaintance with social factors is required, since social and cultural factors may influence some aspects of development, and, equally, physical and developmental disabilities can lead to social problems. MacKeith (1969) sees such work as the responsibility of a new generation of doctors which he calls "Community Paediatricians".

The specialist doctor we have described above will be required to co-operate with a wide variety of specialists, paediatricians, ophthalmologists, E.N.T. surgeons, child psychiatrists, orthopaedic surgeons and others. For this task the doctor must have equal standing with his colleagues and to this end he must be prepared to acquire the necessary clinical skill, knowledge and qualifications. He must be prepared to make home visits, often in co-operation with general practitioner colleagues, and be prepared to work the extra or irregular hours which go with clinical medicine.

We have considered whether paediatricians could undertake this work. The number of paediatricians interested and knowledgeable in the developmental and social aspects of their specialty is increasing, but still remains only a small part of the total. The demand for paediatricians in the hospital service is likely to remain for some time greater than the supply, and in view of the general situation in the paediatric service (B.M.J. 1968) it is clearly impossible for the great amount of work involved to be undertaken by paediatricians in the foreseeable future.

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